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SPECIAL SECTIONS

Abortion in the Middle East and North Africa

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In collaboration with Chr. Michelsen Institute, Bergen, Norway

Abortion Law Reform

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Table of Contents

ABORTION IN THE MIDDLE EAST AND NORTH AFRICA

In collaboration Chr. Michelsen Institute, Bergen, Norway

1 EDITORIAL
The Limits of the Law: Abortion in the Middle East and North Africa
Irene Maffi and Liv Tønnessen

7 The Politicization of Abortion and Hippocratic Disobedience in Islamist Sudan
Liv Tønnessen and Samia al-Nagar

21 Moral Work and the Construction of Abortion Networks: Women's Access to Safe Abortion in Lebanon
Zeina Fathallah

33 Non-marital Pregnancies and Unmarried Women's Search for Illegal Abortion in Morocco
Irene Capelli

47 The Unique Landscape of Abortion Law and Access in the Occupied Palestinian Territories
Sarrah Shahawy

57 Neoliberal Health Restructuring, Neoconservatism and the Limits of Law: Erosion of Reproductive Rights in Turkey
Ayse Dayi

69 The Right to Abortion in Tunisia after the Revolution of 2011: Legal, Medical, and Social Arrangements as Seen through Seven Abortion Stories
Irene Maffi and Malika Affes

ABORTION LAW REFORM

79 EDITORIAL
Progress towards Decriminalization of Abortion and Universal Access to Safe Abortions: National Trends and Strategies
Marge Berer and Lesley Hoggart

85 Eliminating Abortion from Criminal Law: A Just Cause
Ana Cristina González-Vélez, Carolina Melo-Arévalo, and Juliana Martínez-Londoño

97 The Role of Reproductive Justice Movements in Challenging South Korea's Abortion Ban
Sunhye Kim, Na Young, and Yurim Lee

109 From the Grassroots to the Oireachtas: Abortion Law Reform in the Republic of Ireland
Anna Carnegie and Rachel Roth

121 Abortion in Chile: The Long Road to Legalization and its Slow Implementation
Gloria Maira, Lidia Casas, and Lieta Vivaldi

133 Rights-based Claims Made by UK Anti-abortion Activists
Pam Lowe and Sarah-Jane Page

145 Midwives and Post-abortion Care in Gabon: "Things have really changed"
Aimée Patricia Ndembi Ndembi, Justine Mekuí, Gail Pheterson, and Marijke Alblas

157 They Are Girls, Not Mothers: The Violence of Forcing Motherhood on Young Girls in Latin America
Ximena Casas

169 The Gambia's Political Transition to Democracy: Is Abortion Reform Possible?
Satang Nabaneh

181 Preventing State Harassment of Abortion Providers: The Work of the Legal Support Network in Latin America and East Africa
Ximena Casas, Mitchelle Kimathi-Osiemo, Dee Redwine, Claire Tebbets, Karen Plafker

189 Denial of Safe Abortion to Survivors of Rape in India
Padma Bhate-Deosthali and Sangeeta Rege

HUMAN RIGHTS FOR HEALTH ACROSS THE UNITED NATIONS

In collaboration with the O'Neill Institute for National and Global Health Law, Georgetown University, USA

199 Editorial
Human Rights for Health across the United Nations
Benjamin Mason Meier and Lawrence O. Gostin

205 Health and Human Rights' Past: Patinating Law's Contribution
Thérèse Murphy

215 The Right(s) Road to Universal Health Coverage
Helena Nygren-Krug

229 Perspective
Universal Health Coverage: Are We Losing Our Way on Women's and Children's Health?
Flavia Bustreo and Curtis Doebbler

235 UHC2030's Contributions to Global Health Governance that Advance the Right to Health Care: A Preliminary Assessment
Rachel Hammonds, Gorik Ooms, Moses Mulumba, and Allan Maleche

251 The Challenge of Interdisciplinarity in Operationalizing the Right to Health
Gillian MacNaughton and Mariah McGill

263 The Universal Periodic Review: A Valuable New Procedure for the Right to Health?
Judith Bueno de Mesquita

GENERAL PAPERS

279 Editorial
25 Years: Exploring the Health and Human Rights Journey
Carmel Williams, Joseph J. Amon, Mary T. Bassett, Ana V. Diez Roux, and Paul E. Farmer

283 Have Reforms Reconciled Health Rights Litigation and Priority Setting in Costa Rica?
Alessandro Luciano and Alex Voorhoeve

295 "Hay que tener suerte": Gender-based Violence Service Provision in Quito, Ecuador
Chiara Sabina and Diego Pérez Figueroa

309 Evaluating the Impact of Student-run Asylum Clinics in the US from 2016–2018
Madison B. Sharp, Andrew R. Milewski, Claire Lamneck, and Katherine McKenzie

325 Respect, Protect, and Fulfill—or Reject, Neglect, and Regress? Children's Rights in the Time of the Russian "Gay Propaganda Law"
Caroline H. Voyles and Mariana Chilton

EDITORIAL

The Limits of the Law: Abortion in the Middle East and North Africa

IRENE MAFFI AND LIV TØNNESSEN

Since the International Conference on Population and Development (*ICPD*) in Cairo in 1994, sexual and reproductive health and rights have been recognized as key parts of the international development agenda. They now form part of two Sustainable Development Goals: numbers 3 (on good health and well-being) and 5 (on gender equality and empowerment). Although the ICPD's final report did not recognize abortion as a woman's right, it emphasized that in the countries where it is legal, women should have access to safe medical procedures and that more research should be undertaken to understand the phenomenon.[1]

Many policy makers and scholars recognize the legalization of abortion as an essential step to reduce maternal mortality.[2] When governments restrict access to abortion, abortions continue to take place at roughly the same rate.[3] Restrictive anti-abortion laws are associated with high rates of "less safe" and "least safe" abortions and are therefore seen as a determinant of maternal mortality.[4] However, only the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa from 2003 (Maputo Protocol) recognizes abortion as a human right in specific circumstances. It states:

> *State Parties shall take all appropriate measures to ... protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the fetus.*[5]

Only a few North African countries have signed or ratified the Maputo Protocol, and those few have done so only very recently. In 2015, Beji Essebsi, then president of Tunisia, signed the protocol, but Tunisia did not ratify it until 2018, and laws have yet to be harmonized according to its principles. Sudan has signed but not ratified it. Algeria officially ratified the protocol in 2016, but its application is problematic, as abortion in the cases indicated above is not considered a human right under the country's laws. Mauritania ratified the protocol in 2005, but it has not changed its laws; abortion in Mauritania is still criminalized under article 293 of the Penal Code. Egypt, Morocco, and Libya have neither signed nor ratified the protocol.

The impact of abortion bans on women's health in the Middle East and North Africa (MENA) region is understudied, and reliable data on unsafe abortion in countries where access to safe abortion is difficult or nonexistent are lacking. The reason is that states where abortion is illegal do not collect data on that

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topic (or at least do not make them public) and "[s]ocial and political issues constrain the epidemiologic studies related to abortion."[6] Moreover, as stressed by Sarrah Shahawy in this special section, the occupied Palestinian territory is often absent from official statistics, as it is not recognized as a state. However, a 2008 World Health Organization report estimates the yearly total of unsafe abortions to be 830,000 in Western Asia, causing 600 annual maternal deaths, and 900,000 in Northern Africa (Maghreb), causing 1,500 annual maternal deaths.[7] Overall, the report estimates the total number of maternal deaths in Arab countries to be 14,000 in 2007.[8] Wars and displacement in the MENA region also contribute to high levels of maternal deaths (some of which are probably still related to unsafe abortion). The Fragile States Index, produced by the Fund for Peace, currently places five MENA countries (Afghanistan, Iraq, Sudan, Syria, and Yemen) on "very high alert" or "high alert," suggesting that these factors are likely to continue to affect maternal mortality in the near future.[9]

This special section seeks to understand the political and economic dynamics that drive, hamper, and shape the use of criminal law to regulate abortion in the understudied MENA region. It also aims to explore the effects of discourses and policies promoted by states, international agencies, local nongovernmental organizations, political parties, and Islamic organizations on medical practices and social norms shaping modern reproductive subjectivities.

Very few publications exist on abortion in MENA countries, and those that do exist tend to either give a broad overview of the legislation of different states or evaluate Islam's position on abortion.[10] Detailed fieldwork-based studies on actual medical practices, political debates, local legal implementation, moral and social norms, and the trajectories of individual women in MENA countries are very rare.[11] This special section intends to fill this gap by offering new insights into national and local practices present in the MENA region. The section also seeks to contribute to opening a comparative perspective on the region for scholars, health practitioners, and international actors working on abortion in other areas of the world.

Muslim-majority countries reflect remarkable variation in abortion legislation, and religious scholars diverge notably in their theological reasoning.[12] In contrast to extremely restrictive countries such as El Salvador and Poland, and, more recently, several US states that ban nearly all abortions, all countries in the MENA region permit abortion if the pregnant woman's life is in danger.[13] This resonates with Islamic jurists who have historically perceived abortion as generally *haram* (forbidden) after the fetus achieves "ensoulment" (the status of a person), except to save the woman's life.[14] Some MENA countries also permit abortion in cases of a risk to the pregnant woman's physical health (Bahrain, Iraq, Jordan, Kuwait, Libya, Morocco, Oman, Occupied Palestinian Territories, Qatar, Saudi Arabia, and Yemen), a risk to the pregnant woman's mental health (Algeria, Bahrain, Jordan, Lebanon, Morocco, Qatar, and Saudi Arabia), fetal impairment (Iran, Kuwait, Morocco, Qatar, Saudi Arabia, Tunisia, and UAE), or rape (Morocco, Saudi Arabia, and Sudan).

Most abortion laws in the region are punitive and were promulgated during the colonial period, when French and British regimes supported pronatalist policies to increase the population of the metropole and of the colonized lands. As colonial laws criminalizing abortion became entrenched in society, legal and medical services for women desiring abortions also became restricted.[15]

Nonetheless, according to Basim Musallam, abortion was widely practiced in Islamic societies during the colonial period, and the main Islamic schools had different opinions on abortion. Some authorized abortion until 120 days after conception, whereas others were opposed to it.[16] During the 19th century, progressive interpretations of Islam and demographic concerns, coupled with a desire to lower maternal mortality rates, led to laws allowing for abortion on demand during the first trimester in Tunisia and Turkey.[17] However, because these laws were designed not to extend women's rights but to decrease natality rates, they are often applied in a coercive way.

The articles in this special section seek to answer the following questions with case studies

from Morocco, Lebanon, the occupied Palestinian territories, Sudan, Tunisia, and Turkey:

- What are the political dynamics driving the (de) criminalization of abortion?
- What role does religion play in the (de)criminalization of abortion?
- What are the effects of (de)criminalization on different categories of women's access to safe abortion?
- How do international policies and rhetoric concerning sexual and reproductive rights affect political and legal debates on abortion in MENA countries?
- How are neoliberal reforms affecting the political economy of health and the distribution of resources in the domain of sexual and reproductive health?

The six contributions are based on qualitative work and solid long-term knowledge of the field. The authors demonstrate that in several countries in the MENA region, cuts in government health expenditures and the emergence of conservative religiously oriented parties have contributed to the restriction of publicly provided abortion services. This has occurred even in countries such as Turkey and Tunisia that have more progressive laws. The case studies from Turkey and Tunisia show that legalizing abortion is not enough to grant equal and easy access to abortion care, especially for unmarried women from lower socioeconomic classes.

Liv Tønnessen and Samia al-Nagar show how abortion is politicized through its association with illegal pregnancy. Fornication is a crime against God punishable with 100 lashes in Sudan, and pregnancy outside a marriage contract constitutes sufficient evidence of a woman's immorality. This enables a strong link between the crime of fornication and the crime of illegal abortion. Abortion does not normally appear in the domestic political debate on women's reproductive and maternal health. However, it has become politicized in the context of Islamism and militarism in the country, as implementing strict Islamic law often puts control and suspicion of women's sexuality at center stage. In addition, a number of bureaucratic barriers, as well as a strong police presence outside maternity wards in public hospitals, make it difficult for unmarried women to access emergency care after complications of an illegal and often unsafe abortion. Doctors who treat unmarried women suffering such complications are forced to maneuver between their commitment to medical ethics and their compliance with strict government laws and policies. The authors, through what they term "Hippocratic disobedience," show that these practitioners are subverting state law and policy in various ways. Although these doctors personally believe that abortion is forbidden in Islam, they object to the state's disproportionate and unfair punishment of predominantly young, unmarried, and socioeconomically vulnerable women.

In Lebanon and Morocco, criminalization does not appear to be an insurmountable obstacle for women who want to safely terminate a pregnancy under medical supervision. At least for those women who can afford to pay, it seems relatively easy to access abortion care, and most abortions take place in medical facilities with qualified clinicians. Interestingly, in Morocco, rural and poor women are still victims of high maternal mortality compared with the urban population, but in Lebanon, a woman's place of residence does not seem to be relevant. Zeina Fathallah investigates the strategies of Lebanese women to get abortion care and how their interactions with their husband/partner, family members, friends, and doctors shape their abortion itineraries and experiences. She shows that many individuals do not freely choose to terminate their pregnancies but are faced with familial, social, and economic constraints that force them to have an abortion. In most cases, despite the social and legal ban on abortion in Lebanon, women are able to terminate one or several pregnancies under medical supervision in private hospitals and doctors' offices. Health care providers of various confessional groups are ready to offer abortion care in exchange for monetary compensation that varies according to the marital status of the woman, her age, and weeks of pregnancy. Hence, the criminal-

ization of abortion does not dissuade women from terminating a pregnancy but does create and reinforce socioeconomic inequalities, as well as local patriarchal logics and constraints.

As in Lebanon, abortion is illegal in Morocco. However, Irene Capelli shows that it is widely performed by local health providers. Nonetheless, while women who can afford it can easily get abortion care in the main cities of Morocco, unmarried and marginalized women may find it impossible to pay a doctor to perform an abortion. Many such women will therefore try to abort through more or less traditional methods, including herbal remedies, mechanical methods, and cocktails of various biomedicines. Most of the women Capelli interviewed had to keep their pregnancies but received some protection from Moroccan nongovernmental organizations that take care of unwed mothers, a category that has gained visibility in the last decade. Capelli argues that local organizations have produced a new moralizing discourse on abortion that coexists with the legal sanctions. Although the notion of sexual and reproductive rights has been introduced in Morocco, abortion is not considered part of these rights. Furthermore, the state does not recognize unwed mothers as a specific group because the law does not recognize filiation outside of wedlock, and premarital sexuality is socially and legally sanctioned.

In all examined countries, social class, marital status, income, age, and education play an important role. These factors may shape the possibility of accessing abortion care, or, where abortion is legal, they help determine the type of facility women can go to and, consequently, the kinds of experience they have. Shahawy shows that access to abortion for Palestinian women depends on a woman's socioeconomic status and whether she is a resident of Jerusalem, the West Bank, or Gaza. Because abortion is illegal under Palestinian law and highly restricted in the occupied Palestinian territories, Palestinian women are forced to turn to Israeli hospitals, to expensive private Palestinian clinics, or to self-induced termination when seeking an abortion. While Israeli clinics and hospitals provide a unique option for a limited group of Palestinian women, taking advantage of this option is fraught with ethical and political implications that are keenly felt by Palestinians and complicate the abortion landscape. The barriers to accessing abortion under occupation are not only geographic and financial but also psychological and political. Thus, both the legal restrictions and the negative impact of the occupation on freedom of travel create a complex landscape that Palestinian women must navigate when seeking abortion services.

Women's economic and social capital is also crucial in Turkey and Tunisia, where cuts in the financing of the health care system have restricted women's access to abortion services in the public sector. Furthermore, increases in power of Islamist parties and Islamic conservative repertoires circulating in the MENA region help reinforce moral and social norms that condemn sexuality outside of marriage and assign women the traditional roles of wives and mothers. In both Tunisia and Turkey, these discourses have affected health care providers' attitudes and practices: some of them have begun to refuse to offer the services they should provide.

In her contribution, Ayse Dayi emphasizes how neoliberal logics have contributed to dismantling the Turkish welfare state and have caused a restructuring of the health care system. The economic reforms have deeply transformed the professional practices of clinicians in the domain of sexual and reproductive care, reducing, for example, the availability of contraceptive methods and the availability of abortion in the public sector. Dayi shows how these reforms, along with neoliberal reforms, are eroding women's sexual and reproductive rights and promoting a pronatalist and nationalistic discourse. In Tunisia, the economic crisis and the emergence of Islamist and conservative forces have made abortion on request—something that has been legal since 1973—increasingly difficult to obtain in the public sector. Irene Maffi and Malika Affes examine the abortion itineraries of seven women in a large government hospital of the capital to capture the legal, social, economic, and medical constraints that poor women face in the only Arab country where abortion is currently legal. They stress the paradoxical effects of the democratization process

during the post-revolutionary period, which has contributed to reducing, rather than increasing, women's sexual and reproductive rights.

The legalization of abortion is not a magic bullet but is nonetheless important for advancing women's sexual and reproductive rights in the MENA region. Since the *ICPD* in Cairo in 1994, 52 countries worldwide have changed their laws to allow for greater access to abortion. However, only three MENA countries are on that list: United Arab Emirates (in 2014), Morocco (in 2017), and Iran (in 2004) all extended the circumstances under which women can seek an abortion to include fetal impairment.[18] Rarely is abortion on top of the agenda of local women's movements. This is likely due to a fear of backlash, both from the states, which are often explicitly or implicitly seeking legitimacy within Islam, and from the conservative segments of societies themselves, which often aim to control and confine women and girls to stereotypical gender roles. As a new wave of popular uprisings currently sweeps over the MENA region (particularly in Algeria, Iraq, Lebanon, and Sudan), this could be a critical moment to put women's sexual and reproductive rights on the political agenda.

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References

1. A. Guillaume, "L'avortement en Afrique 10 ans après la Conférence du Caire," in B. Ferry, A. Gautier, O. Samuel, et al. (eds), *La situation dans les pays du Sud: Synthèse et ensemble des contributions de chercheurs des institutions de recherches partenaires* (Nogent-sur-Marne: CEPED and United Nations, 2004). Available at http://horizon.documentation.ird.fr/exl-doc/pleins_textes/divers09-05/010041377.pdf.

2. R. Dabash and F. Roudi Fahmi, *Abortion in the Middle East and North Africa* (Washington, DC: Population Reference Bureau, 2008); G. Sedgh, J. Bearak, S. Singh, et al., "Abortion incidence between 1990 and 2014: Global, regional and subregional levels and trends," *Lancet* 388/10041 (2016), pp. 268–267.

3. B. R. Johnson, V. Mishra, A. F. Lavelanet, et al., "A global database of abortion laws, policies, health standards and guidelines," *Bulletin of the World Health Organization* 95 (2017), pp. 542–544.

4. B. Ganatra, C. Gerdts, C. Rossier, et al., "Global, regional, and subregional classification of abortions by safety, 2010–14: Estimates from a Bayesian hierarchical model," *Lancet* 390/10110 (2017), pp. 2372–2381.

5. Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2003), art. 14; see also C. Zampas and J. M. Gher, "Abortion as a human right: International and regional standards," *Human Rights Law Review* 8/2 (2008), pp. 249–294; C. G. Ngwena, "Inscribing abortion as a human right: Significance of the Protocol on the Rights of Women in Africa," *Human Rights Quarterly* 32/4 (2010), pp. 783–864.

6. A. Rastegari, M. R. Baneshi, S. Hajj-Maghsoudi, et al., "Estimating the annual incidence of abortions in Iran: Applying a network scale-up approach," *Iran Red Crescent Medical Journal* 16/10 (2014), p. e15765; see also World Health Organization, United Nations Children's Fund, United Nations Population Fund, et al., *Trends in maternal mortality, 2000 to 2017* (2019), p. 61.

7. World Health Organization, *Unsafe abortion incidence and mortality: Global and regional levels in 2008 and trends during 1990–2008* (Geneva: World Health Organization, 2012), p. 2.

8. Ibid., p. 6.

9. Fund for Peace, *Fragile states index: Annual report 2019* (Washington, DC: Fund for Peace, 2019), p. 7.

10. For publications dealing with state legislation, see, for example, L. Hessini, "Abortion and Islam: Policies and practice in the Middle East and North Africa," *Reproductive Health Matters* 15/29 (2007), p. 75–84; L. Hessini, "Islam and abortion: The diversity of discourses and practices," *IDS Bulletin* 39/3 (2008), p. 18–27; Dabash and Fahmi (see note 2). For publications dealing with Islam's position on Islam, see, for example, B. F. Musallam, *Sex and society in Islam: Birth control before the nineteenth century* (Cambridge: Cambridge University Press, 1989); D. L. Bowen, "Abortion, Islam, and the 1994 Cairo population conference," *International Journal of Middle East Studies* 29/2 (1997), pp. 161–184; O. Asman, "Abortion in Islamic countries: Legal and reli-

gious aspects," *Medicine and Law* 23/1 (2004), pp. 73–89; G. K. Shapiro, "Abortion law in Muslim-majority countries: An overview of the Islamic discourse with policy implications," *Health Policy and Planning* 29/4 (2014), pp. 483–494.

11. Notable exceptions include S. Hajri, S. Raifman, C. Gerdts, et al., "'This is real misery': Experiences of women denied legal abortion in Tunisia," *PLOS ONE* 10/12 (2015), p. e0145338; L. Tonnessen, "Women's rights to abortion after rape in Sudan," *CMI Insight* 2 (2015); I. Maffi and M. Affes, "La santé sexuelle et reproductive en Tunisie: Institutions médicales, lois et itinéraires thérapeutiques des femmes après la revolution," *L'Année du Maghreb* 17/2 (2017), pp. 151–168; M. Gruenais, "La publicisation du débat sur l'avortement au Maroc: L'Etat marocain en action," *L'Année du Maghreb* 17/2 (2017), pp. 219–234; I. Maffi, "Abortion in Tunisia after the revolution: Bringing a new morality into the old reproductive order," *Global Public Health* 13/6 (2018), pp. 680–691; S. Shahawy and M. B. Diamond, "Perspectives on induced abortion among Palestinian women: Religion, culture and access in the occupied Palestinian territories," *Culture, Health and Sexuality* 20/3 (2018), pp. 289–305.

12. Hessini (2007, see note 10); Shapiro (see note 10).

13. K. Lui, "A teenage rape survivor in El Salvador has been jailed for 30 years," *Time* (July 7, 2017), https://time.com/4848547/el-salvador-rape-victim-stillbirth-murder-jail/; A. Sifferlin, "It's almost impossible to get an abortion in Poland: These women crossed the border to Germany for help," *Time* (2019), https://time.com/poland-abortion-laws-protest/; L. J. Reagan, "We don't have to imagine the consequences of abortion bans: We just have to look to the past," *Time* (May 16, 2019), https://time.com/5589993/alabama-abortion-law-history/.

14. Hessini (2007, see note 10).

15. Ibid.

16. Musallam (see note 10).

17. Hessini (2007, see note 10).

18. S. Singh, L. Remez, G. Sedgh, et al., *Abortion worldwide 2017: Uneven progress and unequal access* (New York: Guttmacher Institute, 2018).

The Politicization of Abortion and Hippocratic Disobedience in Islamist Sudan

LIV TØNNESSEN AND SAMIA AL-NAGAR

Abstract

In Sudan's Islamist state, abortion is politicized through its association with illegal pregnancy. Fornication is a crime against God punishable with 100 lashes, and pregnancy outside a marriage contract constitutes sufficient evidence of a woman's immorality. This enables a strong link between the crime of fornication and the crime of illegal abortion, to the extent that our interviewees often conflate the two in the term "illegal pregnancy." While abortion does not appear in the domestic political debate on women's reproductive and maternal health and is not on the agenda of the national women's movement, it has become politicized in the implementation of the law. A number of bureaucratic barriers, in addition to a strong police presence outside maternity wards in public hospitals, make it difficult for unmarried women to access emergency care after complications of an illegal abortion. These women put themselves at risk of arrest for fornication and illegal abortion. However, many doctors, honoring the Hippocratic oath, disobey state policy and refrain from reporting such crimes to the police to protect unmarried and vulnerable women from prosecution.

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Introduction

Unsafe abortion is one of the leading causes of maternal mortality, and abortion-related maternal deaths are generally higher in countries that restrict women's access to induced abortion.[1] In the Middle East and Northern Africa (MENA) region, only Tunisia and Turkey have legalized abortion on demand during the first trimester.[2] Most abortion laws in the region are punitive, and legal services are restricted.[3] In Sudan's Islamist state, induced abortion is a crime except when performed to save the pregnant woman's life, if the fetus has died in the woman's womb, and in cases of rape.[4]

In this article, we explore the political dynamics driving the criminalization of abortion in Sudan and its effects on women's access to abortion-related care in Khartoum. The criminalization of abortion forms an important part of the Islamist government's restrictive ideological stance on women's sexual and reproductive rights generally. Sudan has not ratified any international or regional conventions protecting women's human rights. Abortion is a particularly sensitive area within maternal health and reproductive rights because it is mediated through the crime of *zina* (sexual intercourse before and outside of marriage). Sudan is unique in the MENA region, for pregnancy among unmarried women is considered sufficient evidence for the crime of *zina* as outlined in the 1991 Criminal Code.[5] This enables a strong link between the crime of fornication and the crime of illegal abortion, which shapes politicization in peculiar ways. The prevailing sentiment among Sudan's Islamist officials is that the primary purpose of women is to marry and to produce children—and as long as reproduction takes place within marriage, there is no need for abortion except under special circumstances. According to this view, only unmarried women who get pregnant illegally would seek abortion in order to "hide" the evidence of fornication.[6]

The scarce available research on abortion in Sudan suggests that the high rate of unintended pregnancy, combined with the country's restrictive abortion law and social stigma, forces women to seek illegal and unsafe abortion, often in secrecy from their families.[7] While women who can afford it are able to access safe illegal abortions in the private market (where they may purchase misoprostol), women with lower socioeconomic status must resort to unsafe illegal abortions, which can often lead to complications and the need to seek emergency care at public hospitals.[8]

Based on original data collected through fieldwork between 2011 and 2019, we have found that although abortion does not appear in the domestic political debate on women's reproductive and maternal health and is not on the agenda of the Sudanese women's movement, it is politicized in the implementation of the law. We understand politicization as the politically contested implementation of a law. Our findings indicate that bureaucratic barriers and policies prevent and deter illegal abortion, which is politically and socially viewed as intrinsically linked to illegal pregnancy. These barriers, which contravene women's human rights to health, dignity, and security, are found primarily in public hospitals, where there is an increased police presence outside maternity and emergency wards. Thus, unmarried women in search of lifesaving treatment find themselves under surveillance the minute they enter a hospital building unaccompanied by a male guardian.

The women who seek emergency medical care because of complications after an illegal abortion are at the mercy of doctors in terms of whether they will be reported to the police. We coined the term "Hippocratic disobedience" to capture the subtle and often hidden ways in which Sudanese doctors disobey state policies to protect a vulnerable group of unmarried women from prosecution. They do so at great personal risk, and often against their own personal beliefs that abortion is *haram* (forbidden) in Islam and that fornication is morally wrong.

Data collection and methods

We conducted a qualitative interview-based study in Sudan's capital. In total, we conducted 37 semi-structured interviews with a variety of stakeholders in 2011, 2013, 2015, 2017, 2018, and 2019. We

selected the initial groups of interviewees based on their stake in sexual and reproductive health and rights. From there, we carefully snowballed by using central gatekeepers with whom we have gained trust. We interviewed international donors, medical doctors and midwives in public and private hospitals and medical universities, women's rights activists, politicians, family and child protection units, journalists, and religious scholars. Thirty-three of the interviews were conducted in person in Khartoum, and four were conducted by email. Twenty-eight of these interviews were conducted in English, and five were conducted in Arabic and later translated into English. We personally conducted all interviews. The interviews varied from half an hour to one and a half hours. Because of the sensitivity of the topic, we did not record the interviews, instead taking elaborate notes. All interviewees gave their oral consent to be interviewed. All interviewees remain anonymous.

The majority of those interviewed are medical doctors who are currently working or have recently worked in public hospitals. The sample of medical doctors is somewhat skewed, as we have been unable to reach the outliers, whether those who perform abortions illegally or those who are adamant about reporting illegal pregnancies to the police.

Most of the data collected for this article was gathered in 2018 and 2019 as part of the project "Political Determinants of Sexual and Reproductive Health: Criminalization, Health Impacts and Game Changers." The project investigates the health effects of criminalizing sexual and reproductive behavior and health services, and analyzes the political dynamics that drive, hamper, and shape the uses of such criminal law in nine African countries, including predominantly Christian sub-Saharan countries (Uganda, Malawi, Ethiopia, Kenya, Mozambique, Zambia, and South Africa) and North African Muslim countries (Sudan and Tunisia). Ethical approval for this research was obtained from the Norwegian Center for Research Data (approval number 60055). All interviews were conducted before the fall of President Omar al-Bashir in April 2019. A peaceful popular uprising, which started in December 2018 with doctors and other professionals going on strike, ousted Bashir, who had ruled Sudan since a military coup d'etat in 1989. Some of his key supporters within the military remain in central positions as Sudan now navigates a transition to civilian government.

The study relies heavily on interview data, but we also triangulate our analysis with other data sources, such as legal texts, government health plans and policies, and media reports.

Women's reproductive rights and policy in Sudan

There has been an intensified focus by Sudan's Islamist government on reducing the country's maternal mortality rate, which is currently estimated at 295 maternal deaths per 100,000 live births.[9] However, huge urban-rural disparities exist. The emergency obstetric and neonatal care needed to save lives is weak, and the Sudanese health system is persistently underfunded.[10] Sudan experienced a significant reduction in its maternal mortality rate in 2011, when South Sudan separated from the north and became the country with the world's highest maternal mortality rate. Direct obstetric causes contribute to 60% of maternal deaths in Sudan. This high prevalence is associated with many risk factors, including female genital mutilation/cutting (FGM/C), early childbearing, high fertility, and barriers to accessing maternal health services.[11]

In recent years, women's reproductive health and rights have received heightened attention in government health strategies and action plans as the government struggles to attain the Millennium Development Goal—and the later Sustainable Development Goal—to reduce maternal mortality.[12] In particular, FGM/C (with a prevalence rate of 89%) and child marriage (with a prevalence rate of 34%) have been at the forefront of international aid efforts and the national government's and civil society's reproductive health and rights agendas.[13]

Nonetheless, unsafe abortions and the country's restrictive abortion law have not been part of the public debate on reducing maternal mortality.

Article 135 of the 1991 Criminal Code restricts legal abortion to cases where it is needed to save the woman's life, in cases where the fetus has died in the woman's womb, and in cases of rape occurring fewer than 90 days before the pregnant woman obtains the abortion. The punishment increases from three to five years of imprisonment if the induced abortion takes place after ensoulment.[14] Ensoulment is an Islamic concept whereby the fetus attains personhood, interpreted as 90 days in Sudan's Criminal Code.[15]

According to one of the few studies conducted in Khartoum, the majority of the women seeking abortion services (96.7%) come for the treatment of post-abortion complications or after incomplete abortions.[16] The actual extent of unsafe abortions is unknown in Sudan, due in part to the illegality of abortion.[17] However, considering that contraceptive prevalence is low and the unmet need for family planning is high, it is reasonable to conclude that there is a high number of illegal and unsafe abortions.[18] Family planning has been perceived by conservative political and religious actors as undermining women's natural and primary role in reproduction.[19] Traditional methods for self-inducing abortion include drinking herbs, ingesting various drugs and poisons, and inserting objects into the uterus.[20] Misoprostol has recently emerged as a safe alternative, but only in selected private hospitals and on the black market (of course at a much higher cost).[21]

The available research suggests that only a small minority of women seek legal abortions, doing so primarily to save the pregnant woman's life.[22] Legal abortion after rape is almost impossible to obtain, but emergency contraceptives are distributed by international organizations in conflict areas.[23] Contraceptives (including emergency contraceptives), abortion, and post-abortion care must be administered by a senior doctor, which is a challenge considering the dearth of doctors, especially in conflict-affected and rural areas.[24]

Sudan's legal restrictions on abortion stem from a set of laws codified by the Islamist regime that are discriminatory toward women. Based on conservative interpretations of Islam, Islamists have restricted rather than expanded women's reproductive and sexual rights. Sudan is one of the handful of countries in the world that has not ratified the Convention on the Elimination of All Forms of Discrimination against Women, as government officials believe that it fundamentally contradicts with Sharia law. Nor has Sudan ratified the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, which recommends the legalization of abortion. Internationally, the Islamist government has taken an actively restrictive stance on women's right to abortion. Sudan boycotted the International Conference on Population and Development in Cairo in 1994, stating that family planning and abortion are against Sharia law. It harassed Sudanese civil society organizations that participated in the Cairo conference and demanded the closing of UNFPA's Sudan office, which it saw as an agency conspiring against Sudan's population. In the domestic arena, family planning is seldom part of public debates. However, there has been a slight shift since Cairo in the Sudanese government's policy on abortion. The 2010 Reproductive Health Policy addresses the prevention of abortion and unwanted pregnancies, as well as post-abortion care, for the first time. Further, the 2010–2015 *Roadmap for Reducing Maternal and Newborn Death and Mortality in Sudan* acknowledges unsafe abortion as one of the causes of maternal morbidity and mortality. A potentially revolutionary new inclusion in the roadmap was that mid-level providers could administer misoprostol. In a country with a dearth of doctors—particularly in rural areas, where maternal mortality is the highest—this provision could make a huge difference in reducing the number of hemorrhage-related maternal deaths.

Politicization of abortion through *zina*

Abortion is politicized through its association with the crime of *zina*, a concept within Islamic criminal justice that makes sexual intercourse between individuals who are not married to each other punishable. Such sexual intercourse is criminalized in Sudan's 1991 Criminal Code with 100 lashes for

non-married offenders (fornication) and stoning to death for married offenders (adultery). *Zina* is a *hadd* crime (plural *hudud*), meaning that it is regarded as an ordinance of Allah and has fixed punishments derived from Islamic sources. *Hudud* offenses assume a central place in the call for Sharia by Sudanese Islamists, who consider these to be crimes against Islam itself.

Sudan's Criminal Code follows the Maliki school of Islamic jurisprudence, in which the pregnancy of an unmarried woman is considered sufficient evidence of fornication. However, in the other three Sunni schools of law, pregnancy does not constitute proof of *zina*.[25] Sudan is thus one of the few Islamic countries (along with Iran, Saudi Arabia, Pakistan, and Afghanistan) to have criminalized *zina* and the only one to consider pregnancy as sufficient proof of the crime by unmarried women.

In Sudan, the introduction of *hudud* was embedded in a larger call for Islamization by the Islamists, who came to power through a military coup in 1989. President Omar al-Bashir and his circle of supporters instigated a process of the comprehensive Islamization of Sudanese law. The criminalization of *zina* was an important symbolic component of building an Islamic nation in which the Muslim family is the building block. The Sudanese regime has made control of women's dress and behavior in public spaces a cornerstone of its 30-year rule. For example, women are legally mandated to wear hijab and to dress and behave "decently" and "morally" in public spaces. According to the regime, these laws and regulations are needed to prevent society from descending into *fitna* (sexual chaos). If women dress or behave inappropriately, they will tempt men into premarital sex. Therefore, ensuring that sexual intercourse takes place only within marriage and imposing a strict legal and social control of women's dress and behavior is the Islamists' recipe for a moral and Islamic society.[26]

Against this backdrop, abortion has become a means through which to hide the evidence of the crime of fornication or "illegal pregnancy," as this item was labeled by our interviewees. In fact, when asked about illegal abortion, our informants systematically referred to it as illegal pregnancy. As seen in the testimony below, which was from an interview with an Islamist, the fear of premarital sex is what drives the politicization of abortion:

> *Although Islam gives more freedom than Christianity on abortion, it cannot be put into the law. If this is put into the law, people will take the decision every day. There is fear that girls will have premarital sex and get pregnant every month. Free abortion is legalization of zina. (interview, 2017)*

Illegal pregnancy is a sign of legal and social misconduct; therefore, it is unthinkable that a married woman would seek an abortion, as her main duty is a reproductive one. In the Sudanese context, it is thought that only an unmarried, immoral woman would want an abortion. In the words of Sudanese women's rights activist:

> *Abortion is a clear indication of misconduct. Added to that, in Muslim communities, having children is regarded as the most noble thing to do, so even the feeling of not wanting a child is a huge mistake. Part of women's value, and in fact the most important part for women, is to be fertile and give birth to as many possible children, and women who even think of having space between deliveries is questioned. A woman's femininity is measured by her ability to give birth to children. (interview, 2017)*

According to conservative political and religious elites, if abortion becomes readily available, it would be an incentive for unmarried women to commit immoral crimes ("illegal pregnancies"), and Sudan would descend into moral chaos. This position was demonstrated in a rare public debate on the topic when DKT International and the United Nations Population Fund were allowed to provide training to health care workers on post-abortion care. During 2005–2011, DKT International was the largest nongovernmental provider of reproductive health products and services in Sudan.[27] Sudanese medical schools offer little to no training on post-abortion care. Religious conservatives fear that such training and the availability of equipment would encourage "illegal" pregnancies and that abortion would be the means by which women and girls could get away with immorality. A religious scholar at Africa

International University, who has been working as a religious and health advisor to the National Council for Child welfare, summarized it thus:

> *Islam is clear on abortion, it is haram, but there is legal abortion in case three obstetricians and gynecologists confirmed harm to mother from presence of baby or if the baby is 100% deformed. But abortion outside marriage is not allowed. We cannot solve a crime with a crime. The unmarried girls do not keep moral and get pregnant and many of them just throw their babies in Maigoma orphanage. They do not take responsibility for their mistakes. Any opening to abortion means giving girls the opportunity to have sex as they want … We are a conservative society, and there should be discipline. (interview, 2019)*

The fear that unmarried women will fornicate and use illegal abortion to hide the evidence of their crime therefore drives the government to impose bureaucratic barriers. For example, in Sudan, it is not possible to give birth in a public hospital without first providing a marriage certificate.[28] Barriers such as these violate women's right to health.

Bureaucratic barriers

According to the *Roadmap for Reducing Maternal and Newborn Death and Mortality in Sudan*, misoprostol can and should be administered by mid-level health providers. However, this has not been implemented out of fear that midwives would use it for illegal abortion. Strict procedures are in place in order to prevent misuse. Misoprostol is available only in pharmacies in maternity hospitals and must be prescribed by a senior obstetrician-gynecologist with a signature and hospital stamp. Midwifes can use it only under supervision. "Why the bureaucratic hurdle? Because midwives help in illegal abortion. So that is why they keep it from them" (interview with obstetrician-gynecologist, 2018).

According to a women's rights activist, misoprostol has not been made available to mid-level health providers because there is a fear it could be used to carry out illegal abortions:

> *The Roadmap is not implemented. Decision makers are influenced by religious ideas and think that if midwives accessed the drugs they can use it for aborting unmarried girls and that would spread immorality. They are more concerned with morality than lives of women. (interview, 2019)*

Another bureaucratic barrier is Form 8, a one-page reporting document produced by the Ministry of Justice in 1991 to record physical injuries related to criminal acts. The 1991 Criminal Procedure Act requires that victims of violence-related crimes (including illegal abortion) file a police report involving Form 8, which patients must bring in order to receive health care at a public hospital. Without this form, health care providers cannot legally treat the patient, regardless of how critical the patient's condition is.[29] In other words, if a woman has sought an illegal abortion and suffers life-threatening complications, she must first retrieve Form 8 at a police station before seeking treatment at a public hospital. Once the health care provider is given the form, the provider proceeds to describe the injury and possible causes, which can later be used in a criminal prosecution of the case.

Although the minister of justice declared in 2016 that health care providers should provide treatment in emergency cases, even if a patient has not obtained Form 8, this directive has not been disseminated to health institutions, and many health care providers and police are unaware of the policy change. This was confirmed in several of our interviews with medical doctors. As a young woman obstetrician said, "I have been working for two years in several hospitals in Khartoum. We have not heard of the announcement from the Ministry of Justice" (interview, 2019). Thus, withholding treatment until the patient presents Form 8 is still common practice.[30] Sometimes it is the police officers patrolling maternity wards who insist on it.

One obstetrician-gynecologist recalled a case where the police arrived at a maternity ward in a public hospital in Khartoum and insisted on receiving Form 8 before medical care could be given in an emergency case:

> *The security said to the doctor that she needed to get Form 8 before she is seen at the emergency room, but the doctor said that this can wait. However, he*

> *threatened the doctor and said that if she escapes then this is his responsibility. So the doctor said to the police that if she died then this is his responsibility because he delayed her treatment. (interview, 2018)*

According to the health workers we interviewed, however, women are more likely to be arrested for illegal pregnancy than for illegal abortion. One doctor who also teaches at a medical school told us, "Punishment for illegal abortion is not so common for women. However, for midwives and doctors there is a high risk of arrest" (interview, 2018). Although abortion is not part of the public political discourse, the arrest of doctors and midwives for performing illegal abortion sometimes spills out into the media. One well-known case is that of Abdulhadi Ibrahim, who was jailed for providing illegal abortions. The court found him guilty of failing to report to authorities that he was treating unmarried pregnant women.[31] In a more recent case, the Sudanese media reported that the police uncovered an illegal abortion clinic after arresting a group of prostitutes, one of whom was in critical condition due to complications after an illegal abortion. After the police interrogated the woman, she led them to the illegal clinic.[32]

Policing maternity wards

To enter a maternity ward, one must go through a gate guarded by police officers; once inside the facility, police officers operate in plain clothes. According to our interviewees, the police presence at public hospitals is higher than at other health clinics and hospitals. Any woman who comes to the hospital alone is suspected of an illegal pregnancy. One obstetrician-gynecologist at a public hospital in Khartoum described it thus: "Are you married? Where is your husband? If you enter a maternity ward alone, you are a suspect" (interview, 2018).

If a woman is suspected of an illegal pregnancy, the police question her while at the hospital, sometimes even while she receives medical care: "One time during an emergency C-section, the police showed up in the operating hall, asking where her husband is, because they thought it was an illegal pregnancy" (interview with an obstetrician-gynecologist, 2018). Another obstetrician-gynecologist recalled a case where the police were so eager to arrest a woman for an illegal pregnancy that they handcuffed her during childbirth:

> *Security staff and police treat women badly, as if they are the judges, even before presenting her case to the legal system. One time, a woman pregnant with twins was kept handcuffed the whole time, and she was discharged directly to the prison because of illegal pregnancy. (interview, 2018)*

This intrusive police presence at public hospitals can make it difficult for doctors to provide medical care with dignity and integrity to patients suffering complications after an illegal abortion.

Abortion, while not frequent in the public discourse, is politicized through its association with illegal pregnancy, a crime against God under Sharia law. Therefore, illegal abortion—a means through which women who have committed the crime of *zina* can be discovered—is strictly policed.

Hippocratic disobedience

Whether a woman with an illegal pregnancy is reported to the police depends on the ideological view of the doctor. In other words, it is a matter of luck. A women's rights activist put it like this:

> *The treatment of the women seeking this care is highly dependent on the medical practitioner's morals. Some adhere to the professional ethics and provide the care without violating the privacy and secrecy principle, and some work like informers to the police because of their obligation to the religion and society. (interview, 2015)*

Most of our interviewees stated that they would not report a woman to the police. In other words, they would disregard Form 8 and treat the case as a miscarriage, without disclosing that the woman is unmarried.

However, our sample is skewed toward younger female obstetrician-gynecologists—we were unable to reach either the most conservative doctors likely to report to the police or the most liberal who would perform illegal safe abortions. The

doctors we interviewed find the strong police presence and control at hospitals highly inappropriate, as it encourages the disproportionate punishment of vulnerable patients. In our interviews, they described how they subvert this police presence because they feel that reporting patients to authorities contradicts their Hippocratic oath. Moreover, the medical ethics guidelines issued by Sudan's Medical Council in 2013 stipulate that doctors are not legally obliged to report illegal pregnancy, concealed birth, or illegal abortion unless it results in death.

We identified two ways that doctors disobeyed the Islamist government policy toward medical care of patients with illegal pregnancy/ illegal abortion: not filling out Form 8 and advising patients to lie or lying on their behalf to distract the police

Not filling out Form 8

In criminal cases, doctors are supposed to fill out Form 8 and report the case to the police. However, most of the doctors we interviewed reported that they did not comply with this policy. One of the crucial questions in determining whether a pregnancy is illegal is assessing whether the patient is married. As stated previously, pregnancy outside marriage is evidence of the crime of fornication. In the words of one obstetrician-gynecologist, "Most doctors take a neutral position to whether the patient is married or not married. They will do their duty and save her life regardless. I had a case, but I did not report it to the police" (interview, 2018). Another doctor and lecturer at a medical university in Khartoum said in a similar vein:

> *I have never reported … I teach students that if they discover an illegal abortion that they should take absolute care and not report it … Ethically you have to treat people without stigma … I tell my students to ignore Form 8. (interview, 2018)*

This means that the case is registered in hospital files as a complication due to miscarriage rather than a complication due to unsafe abortion.

Advising patients to lie or lying on their behalf

When women enter maternal wards alone, they are a suspect in the eyes of the police. In such cases, as described above, the police sometimes interfere with the patient's medical treatment by questioning or handcuffing the woman. According to our interviewees, one of the strategies used by doctors to evade the attention of the police is to lie on the patient's behalf or encourage her to lie when asked about her marital status, such as by saying that her husband is working abroad. One obstetrician-gynecologist recalled a case:

> *A young lady came in. She was illegally pregnant. The police came and said she was illegally pregnant. I lied and said her husband was in Saudi Arabia. I stayed with her until morning to make sure they did not come back to arrest her … I never reported to the police. Most doctors do not report. They do not want to feel guilty for the girl. I do not believe in killing a baby, but … there is strong agreement among doctors that abortion is haram. (interview, 2018)*

In protecting these women from prosecution for illegal pregnancies, doctors run their own risk of being arrested. In the words of one general physician, "It is illegal and it can end your career" (interview, 2018). They do this despite their own personal beliefs that illegal pregnancy is morally wrong. This is well illustrated by the observation of one obstetrician-gynecologist we interviewed:

> *I personally will not induce abortion for a case of adultery because of moral reasons, but if she came with incomplete abortion I can complete it … I remember that a 23-year-old girl came to the maternity hospital to buy misoprostol at whatever cost but we said that we can't give it to her. And then she came with incomplete abortion because she went to a midwife … This is not my business to judge the patients, quite the opposite, those cases need counseling. Even the legal system shouldn't punish her for that. The patient who came to me to get misoprostol and she came later with incomplete abortion, my feeling at that time was that I was sorry for her and I never felt that she should be punished. That was because she will be punished enough by the psychological impact of her doings and the stigma of losing her virginity. (interview, 2018)*

The belief that illegal pregnancy is morally wrong and illegal abortion is against Islam was prominent

among the doctors we interviewed. But through their actions, the doctors object to the Islamist state's disproportionate and unfair punishment of predominantly young, unmarried, and vulnerable women and the state's obstruction of dignified care without prejudice. In the words of an obstetrician-gynecologist, "the role of health workers is not to judge the patient" (interview, 2018). Doctors are bound by the medical oath, which states that they must provide equal medical care for everyone, whether virtuous or a sinner, a friend or an enemy, rich or poor, and regardless of race or religion.[33] When treating an unmarried woman suffering complications after an illegal abortion, doctors' ethical commitment toward the patient trumps compliance with what is perceived as unjust and disproportionate punishment.

The stigma of losing one's virginity before marriage is regarded as a sufficient punishment that carries "implications for the rest of the girl's life" (interview with obstetrician-gynecologist, 2018), especially because it reduces the possibility of a good marriage, which in the Sudanese context is an important symbol of a family's good reputation and honor. Therefore, the punishment of 100 lashes for the crime of fornication is often viewed as disproportionate. It is also considered unfair that the punishment applies only to women, not men. As one doctor stated, "The blame is put on the women only. Nobody is talking about the man" (interview, 2018).

We have coined the term "Hippocratic disobedience" to capture the way in which Sudanese doctors disobey state policies to protect patients from prosecution. Inspired by Ronald Dworkin's different types of civil disobedience and Robert Macauley's notion of "Hippocratic underground," the concept of Hippocratic disobedience consists of refusing to do something that the law requires a person to do on political-moral grounds and with the aim of protecting a vulnerable group.[34] We base this idea on two streams of literature.

The first of these is the literature on conscientious objection, which defines such objection as "the refusal to participate in an activity that an individual considers incompatible with his/her religious, moral, philosophical, or ethical beliefs."[35] The literature focuses on whether conscientious objection hinders women's rights and access to abortion in both liberal and restrictive legal contexts.[36] What we have described in Sudan cannot be captured by this concept, as doctors are providing care *despite* their personal religious-moral belief that abortion is wrong. However, the acts of the doctors interviewed for this study do share some traits with conscientious objectors in that they do not necessarily try to publicize their actions or their reasons for breaking the law. In other words, the disobedience of the doctors we interviewed is hidden to the public. It also consists of individual acts in a doctor's everyday professional life rather than a collective or organized effort. As such, the disobedience is not necessarily linked to a resistance against the system as a whole or to the cause to liberalize the abortion law.

The second stream of literature that influences our idea is that regarding civil disobedience, given that the acts described above go beyond "objection": doctors refuse to follow policies and protocols to report women to the police, an act better described as disobedience. Like conscientious objection, civil disobedience is motivated by sincere views about what is morally right. Civil disobedience is defined by John Rawls as "a public, nonviolent, conscientious, yet political act contrary to law usually done with the aim of bringing about the change in the law or policies of the government."[37] According to James Childress, it is driven by moral-political grounds, in contrast to conscientious objection, which is driven by personal-moral or religious-moral grounds.[38] The concept of civil disobedience is restricted to acts that are political—and in the field of medicine, it has historically related to support for vulnerable groups.[39] In this case, the disobedience is related to the state's disproportionate and unfair punishment for women who are already in a vulnerable position. Against the backdrop of an authoritarian and Islamist state, the disobedience displayed by Sudanese doctors is, however, not public.

Transformative potential?

There has been no legal mobilization, whether by

health workers or the women's movement, to liberalize the right to abortion in Sudan. Unsafe abortion is at the bottom of the list of priorities in terms of reducing the country's maternal mortality rate.

There are several reasons for this lack of mobilization. The first relates to the *fear of double backlash*, from both the authoritarian Islamic state and from the country's conservative society.

Abortion (except to save the woman's life) is widely recognized as going against Islamic doctrine. However, there are multiple interpretations in Islamic jurisprudence as to under what circumstances women can induce abortion and as to when ensoulment occurs.[40] It is the association with *zina* and pregnancy outside marriage that makes it almost impossible to mobilize for legalization in Sudan, for questioning the religious doctrine upon which the *hadd* crime of *zina* is based means risking being accused of challenging Islam itself, which could lead to accusations of being an apostate (a crime punishable with death in Sudan). In addition, the state goes to great lengths to make sure that interest groups do not work on sensitive topics such as abortion. Empowered by the 2006 Voluntary and Humanitarian Work Act, the government can (and does) impose severe restrictions on the work of national and international nongovernmental organizations. The political space for advocacy on abortion is therefore largely nonexistent, and as far as we know, there are only two groups that work on sexual and reproductive rights beyond a focus on FGM/C and child marriage—and they do this work under a low profile. In the words of a women's rights activist, "The security may not allow NGOs to work on reproductive rights issues" (interview, 2019).

The women's rights activists we interviewed pointed to a fear of stigma and backlash from the community if they mobilize for the liberalization of abortion. Abortion is a taboo topic and popularly believed to be equivalent to infanticide, which is also the terminology often used by pro-life movements in the West. As noted by one activist:

> *People do not feel sympathetic to a decision that they perceive as killing a child. They blame the woman … They refer to a Quranic verse that condemns and prohibits infanticide and that you should rely on God to take care of the child. (interview, 2017)*

The victim is therefore the fetus, and not the woman or girl who has become pregnant unintentionally. Although FGM/C was an equally taboo topic a decade ago, women's rights activists interviewed claim that it is easier to put this violent and harmful act in which the girl child has no say on the agenda because "in FGM/C, the girls are victims" (interview, 2017). Therefore, advocacy against FGM/C is related to children's rights. Abortion, on the other hand, relates to a woman's right to make decisions concerning her body, including how many children she wants—if any—and when she wants them.

In sum, were the women's movement to advocate for abortion liberalization, it would face backlash not only from the Islamist state but also from the community at large. One activist summed it up thus:

> *It is a very sensitive subject and linked to religion in a state like Sudan. Sudan boycotted the Population Conference of 1994 for reasons linked to religion. Family planning and abortion is among these reasons. Therefore, it was difficult for the feminist movement to address the issue of abortion; even the community itself would not accept it. (interview, 2019)*

The second reason relates to *conservative attitudes among women's rights activists and doctors*. Younger women's rights activists support a liberalization of the abortion law and place it within the context of sexual rights and freedoms. However, the extent to which the topic is debated is in closed groups on social media, like Whatsapp. The majority of our interviewees (including doctors and activists alike) regard it as morally and religiously wrong. The women's movement is therefore divided on whether the liberalization of abortion is a just cause. Conservative attitudes are predominantly framed within religion and social values connected to the institution of marriage. One activist said:

> *Extending the circumstances for legal abortion is a problem. Allowing for abortion means approving*

> *socially immoral and un-Islamic relations and this affects young women opportunities for marriage. (interview, 2019)*

It is interesting to note that conservative attitudes go across Islamic-secular divides. In the words of an activist:

> *I know that abortion is made illegal by Islamic laws … Some progressive young activists are for sexual freedoms and rights, but as a Marxist I think that we must be careful so that freedoms may not lead to commoditization of our bodies, or to prostitution. (interview, 2019)*

While most of those interviewed oppose a complete decriminalization of abortion, they are open to expanding the circumstances under which abortion is permitted, such as in cases of fetal deformity. It was also clear from our interviews that rape is often regarded as a circumstance in which abortion is allowed. However, interviewees also expressed that this right is limited to emergency contraception in conflict zones. Surprisingly, most of the women's rights activists and obstetrician-gynecologists we interviewed did not know that abortion after rape is allowed within 90 days. One women's rights activist who works at a trauma center for victims of sexual violence said:

> *This is the first time I know of such a law giving the right of abortion after rape. The question that came to my mind is why there are … thousands of children with unknown fathers [as a result of rape]. (interview, 2019)*

This is despite the fact that sexual violence has emerged as a top priority in the legal reform agenda of the women's movement. The focus of women's rights activists has been to provide better legal protection for rape victims, something that culminated in a legal reform in February 2015.[41]

It is clear that in their aims to reduce maternal mortality and strengthen women's reproductive rights, interest groups prefer not to address the issue of unsafe abortion. Maybe they are justified in their focus on abandoning FGM/C and child marriage, as these harmful practices are widespread in Sudan. The perhaps unintended consequence of Hippocratic disobedience is that we do not know the magnitude of unsafe abortion and the negative effect that it has on the country's maternal mortality rate. Given that doctors' Hippocratic disobedience means that unsafe abortions are not officially registered, they remain hidden in official statistics.

Conclusion

Women's access to abortion in Sudan is politicized due to its association with *zina*. When treating unmarried women suffering complications after illegal and unsafe abortions, doctors are forced to maneuver between their commitment to medical ethics and their compliance with government laws and policies. Our findings suggest that these practitioners, in various ways, are subverting state law and policy through what we term "Hippocratic disobedience": protecting a vulnerable group of women from prosecution to give them dignified care without prejudice. Although these doctors personally believe that abortion is forbidden in Islam, they object to the Islamist state's disproportionate and unfair punishment of predominantly young, unmarried, and socioeconomically vulnerable women.

Meanwhile, women's rights activists have not been mobilizing for the legalization of abortion due to the restrictive context of an Islamist state that exercises strict control over and suspicion of women's sexuality. As Sudan transitions from the Islamist-military regime of Omar al-Bashir to a civilian government, there may be new political space for a public debate and greater potential for the advancement of women's reproductive and sexual rights. A sovereign council consisting of both military and civilian actors will rule Sudan for three years, after which free and fair elections will be held. The military council and the coalition representing peaceful protesters have agreed on a new constitutional declaration that enables reform of Sudan's gender discriminatory laws. According to the constitutional declaration, one of the pri-

mary aims of the transitional government will be to "conduct legal reforms that guarantee women's rights, by repealing all laws that discriminate against women, and protect the rights."[42]

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References

1. S. M. Latt, A. Milner, and A. Kavanagh, "Abortion laws reform may reduce maternal mortality: An ecological study in 162 countries," *BMC Women's Health* 19/1 (2019).

2. L. Hessini, "Abortion and Islam: Policies and practice in the Middle East and North Africa," *Reproductive Health Matters* 15/29 (2007), pp. 75–84.

3. Ibid.

4. "Sudan: The Criminal Act 1991," *Arab Law Quarterly* 9/1 (1994), pp. 32–80.

5. L. Tønnessen, "When rape becomes politics: Negotiating Islamic law reform in Sudan," *Women's Studies International Forum* 44 (2014), pp. 145–153.

6. L. Tønnessen and S. al-Nagar, *Women and girls caught between rape and adultery in Sudan: Criminal law reform, 2005–2015* (Bergen: Chr. Michelsen Institute, 2015), p. 10.

7. J. W. Kinaro, T. E. Mohamed Ali, R. Schlangen, and J. Mack. "Unsafe abortion and abortion care in Khartoum, Sudan," *Reproductive Health Matters* 17/34 (2009), pp. 71–77; W. Elamin, A. B. Fazari, and K. Elmusharaf, "A qualitative study exploring women's experiences of unsafe abortion in Sudan," *Open Journal of Social Sciences* 5 (2017), pp. 149–158.

8. L. Tønnessen, "Women's right to abortion after rape in Sudan," *CMI Insight* 2 (2015).

9. World Health Organization, *Trends in maternal mortality 2000–2017: Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division* (Geneva: World Health Organization, 2019).

10. G. Hussein Ibrahim, "The role of the health system in women's utilisation of maternal health services in Sudan" (PhD thesis, London City University , 2015), p. 36.

11. Ibid., p. 22.

12. Republic of Sudan Federal Ministry of Health, *The National Strategy for Reproductive Health 2006–2010* (Khartoum: Federal Ministry of Health, 2006); Republic of Sudan Federal Ministry of Health, *Road Map for Reducing Maternal and Newborn Mortality in Sudan (2010– 2015)* (Khartoum: Federal Ministry of Health, 2009).

13. S. al-Nagar and L. Tønnessen, "Women's rights and the women's movement in Sudan (1952–2014)," in B. Badri and A. M. Tripp, *Women's activism in Africa* (London: Zed Books, 2017), pp. 121–156.

14. "Sudan: The Criminal Act 1991" (see note 4).

15. Hessini (see note 2).

16. Kinaro et al. (see note 7).

17. A. A. Gerais, T. Umbeli, B. Imam, et al., "Situational analysis of unsafe abortion in Sudan" (unpublished presentation).

18. Elamin et al. (see note 7).

19. DKT International, "DKT Sudan: Ensuring the right for all to quality family planning options since 2005," Sudan White Paper. Available at http://www.dktinternational.org/wp-content/uploads/2011/04/DKTWhitePaperSudan.pdf.

20. Kinaro et al. (see note 7).

21. Tønnessen (see note 8).

22. Kinaro et al. (see note 7).

23. Tønnessen (see note 8).

24. Ibid.

25. Z. Mir-Hosseini and V. Hamzic, *Control and sexuality: The revival of Zina laws in Muslim contexts* (London: Women Living Under Muslim Laws, 2010).

26. A. Abdel Halim, "Gendered justice: Women and the application of penal laws in the Sudan," in L. Oette (ed), *Criminal law reform and transitional justice: Human rights perspectives for Sudan* (Farnham: Ashgate, 2011); S. A. Nageeb, *New spaces and old frontiers: Women, social space, and Islamization in Sudan* (Lanham, MD: Lexington Books, 2004).

27. DKT International (see note 19).

28. C. Fluehr-Lobban, *Shari'a and Islamism in Sudan: Conflict, law and social transformation* (London: Tauris, 2012), p. 125.

29. K. Abuelgasim, "Who do I turn to? The experiences of Sudanese women and Eritrean refugee women when trying to access healthcare services in Sudan after being subject to gender-based violence" (Master thesis, Uppsala University, 2018).

30. Ibid.

31. "Sudan: Gynecologist remains defiant about abortion," *AllAfrica* (September 19, 2011). Available at https://allafrica.com/stories/201109201259.html.

32. "Season of abortion among young women: Dr Abdu is in hands of police," *Al Sudani* (February 13, 2018), p. 5.

33. Abuelgasim (see note 29).

34. R. Dworkin, *A matter of principle* (Cambridge, MA: Harvard University Press, 1985); R. Macauley, "The Hippocratic underground: Civil disobedience and health care reform," *Hasting Center Report* 35/1 (2005), pp. 38–45.

35. W. Chavkin, L. Swerdlow, and J. Fifield, "Regulation of conscientious objection to abortion: An international comparative multiple-case study," *Health and Human Rights Journal* 19/1 (2017), p. 55.

36. See, e.g., ibid.; L. Cabal, M. A. Olaya, and V. M. Robledo, "Striking a balance: Conscientious objection and reproductive health care from the Colombian perspective," *Health and Human Rights Journal* 16/2 (2014), pp. 73–83; G. Ortiz-Millan, "Abortion and conscientious objection: Rethinking conflicting rights in the Mexican context," *Global Bioethics* 29/1 (2018), pp. 1–15.

37. J. Rawls, *A theory of justice* (Oxford: Oxford University Press, 1971), p. 365.

38. J. F. Childress, "Civil disobedience, conscientious objection, and evasive noncompliance: A framework for the analysis and assessment of illegal actions in health care," *Journal of Medicine and Philosophy* 10 (1985), p. 67.

39. Macauley (see note 34).

40. L. Hessini, "Islam and abortion: The diversity of discourses and practices," *IDS Bulletin* 39/3 (2008), pp. 18–27.

41. L. Tønnessen, "Enemies of the state: Curbing women activists advocating rape reform in Sudan," *Journal of International Women's Studies* 18/2 (2017).

42. For English translation of the Constitutional declaration signed in August 2019, see http://constitutionnet.org/sites/default/files/2019-08/Sudan%20Constitutional%20Declaration%20%28English%29.pdf.

Moral Work and the Construction of Abortion Networks: Women's Access to Safe Abortion in Lebanon

ZEINA FATHALLAH

Abstract

This study explores the intersectional effects of criminalization on women's access to safe abortion in Lebanon. Building on 119 original interviews with women who have had an abortion and physicians who offer safe abortion services, the article analyzes women's experiences through two themes: decision making and accessibility to safe abortion services. The article finds that a woman's decision to abort is morally conflicted and largely dependent on her partner: in the case of single women, this turns on whether the partner is willing to marry the woman and assume paternity of the future child, while in the case of married women, this turns on the husband's agreement with the wife's decision. Women use social networks to gain access to information and to clandestine abortion services. Most of the physicians offering abortion services act as moral gatekeepers, often condemning the woman and preserving certain social norms rather than advocating for women's bodily autonomy and free choice. This article argues that the right to safe abortion is a privilege rather than a right in the restrictive Lebanese context, since access to services hinges on a woman's social capital, networks, and ability to negotiate with partners and physicians. Single women from a lower socioeconomic background stand out as the most vulnerable.

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Introduction

This study explores the intersectional effects of criminalization on women's access to safe abortion in Lebanon. Lebanon's Penal Code, which dates back to 1943, bans abortion except to save the pregnant woman's life. The article explores how women experience abortion across marital status, religion, and socioeconomic status and how women who seek abortion create a space of autonomy in a clandestine context. Building on 119 original interviews conducted between 2003 and 2008 with women who have had an abortion and physicians who offer safe abortion services, the article analyzes women's negotiations with their partners, allies within their networks, and physicians through two themes that emerged from the data material: decision making and accessibility to safe abortion services.

Since 1969, there have been no attempts to expand the circumstances under which women can lawfully seek an abortion in Lebanon. The absence of liberalization of the law, combined with scant research on the effects of criminalization, suggests that abortion is not a public health issue of concern.[1] The scant research available has tried to calculate the number of abortions at one hospital in Beirut and has explored the attitudes of health professionals more generally. For example, William Bickers attempts to estimate the number of abortions in Lebanon based on the number of admissions for spontaneous or induced abortions at the American Hospital of Beirut.[2] However, there is still no accurate information on the number of legal *and illegal* abortions in Lebanon. (The total number of *legal* abortions, including spontaneous abortions, reported by hospitals to the Vital Data Observatory at the Ministry of Public Health was 10,913 in 2014.[3]) L. Zahed, M. Nabulsi, and H. Tamim assess the attitudes of health professionals in Lebanon toward prenatal diagnosis and termination of pregnancy for a series of genetic, non-genetic, and non-medical conditions, finding that the highest percentage of positive attitudes toward abortion (90.5%) relates to abortions following pregnancies resulting from rape, while the lowest percentage (20%) relates to abortions sought by pregnant married women without their husbands' knowledge.[4] The prevailing literature also emphasizes the fact that criminalization puts a huge burden on health professionals. For instance, Thalia Arawi and Anwar Nassar argue that the Lebanese law on abortion should be amended to allow for abortions based on prenatally diagnosed fetal malformations because they are justified in the interest of the fetus and the child.[5] They note that "obstetricians are confronted with the burden placed on them under the law to refuse termination of pregnancy, or, when performing them, to forge records or deny having done them."[6]

Furthermore, empirical research on abortion in Lebanon, especially within the social sciences, is not currently available. This study is the first of its kind to explore women's experiences and physicians' practices. Unlike other contexts in the Middle East and North Africa region where restrictive laws lead to unsafe abortions, Lebanon's criminalization of abortion is not an insurmountable obstacle for women who want to safely terminate their pregnancy under medical supervision.[7] However, the ability to obtain a safe abortion is a privilege in the restrictive Lebanese context, where access to services hinges on a woman's social capital, networks, and ability to negotiate with partners and physicians. Most physicians who offer abortion services act as moral gatekeepers, often condemning the woman and preserving certain social norms rather than advocating for women's bodily autonomy and free choice. Single women from lower socioeconomic backgrounds are particularly vulnerable in these negotiations, given that premarital sexuality is still prone to stigmatization. Thus, marital status and socioeconomic background shape the possibility of accessing safe abortion care and the kinds of experiences women have.

The criminalization of abortion in Lebanon

The Lebanese Penal Code established in 1943 both outright prohibits abortion under all circumstances and bans the selling of substances used to induce abortion (arts. 539–546). Under article 541, a woman having an abortion is subject to imprisonment of six months to three years, and the person performing the abortion is subject to imprisonment of one

to three years. Nonetheless, article 545 stipulates that a woman who has an abortion to "save her honor" would benefit from an attenuating excuse. Although the circumstances under which an abortion is considered to save one's honor are not stated in the Penal Code, they include various situations, such as pregnancy among unmarried pregnant women and pregnancy resulting from rape. The benefit of an attenuating excuse also applies to the person contributing to an abortion in order to save the honor of a family member or a relative with or without the woman's consent.

Presidential Decree No. 13187, dated October 20, 1969, reaffirms the prohibition of abortion but modifies the Penal Code by permitting it if needed to save the pregnant woman's life (therapeutic abortion). Therapeutic abortions are currently allowed based on the conditions specified in article 32 of Medical Ethics Law No. 288 of February 22, 1994, which indicates that the attending physician, before performing an abortion, must consult with two other physicians who have also performed a medical examination, and they all must agree that the woman's life can be saved only through an abortion.

The government of Lebanon voted for the Universal Declaration of Human Rights and has ratified a number of international instruments dealing with health and human rights, including the International Covenant on Economic, Social and Cultural Rights and the Convention on the Elimination of All Forms of Discrimination against Women.[8] Lebanon's ban on abortion is part of a legal architecture that limits women's rights generally in the country. For example, Lebanese women do not have the right to pass on their nationality to their children or to a foreign husband. Depending on their sectarian affiliation, women also suffer from several inequalities within the country's personal status laws.[9] When ratifying the Convention on the Elimination of All Forms of Discrimination against Women, Lebanon therefore entered reservations against several articles:

- article 9(2) (equal rights with respect to nationality of the children);
- article 16(1)(c), (d), (f), and (g) (equal rights, divorce rights, parenting, custody of children, and the "same personal rights as husband and wife, including the right to choose a family name, a profession and an occupation"); and
- article 29(1) (administration of the convention and arbitration in the event of a dispute between state parties).

In its concluding observations submitted to the Lebanese state in 2015, the United Nations (UN) Committee on the Elimination of Discrimination against Women called for the decriminalization of abortion, at least where the pregnancy poses a threat to the pregnant woman's life or health and in cases of rape, incest, and severe fetal impairment.[10] In 2018, the United Nations Population Fund, United Nations Development Programme, and UN Women issued a joint recommendation calling on Lebanon to develop a national human rights strategy related to sexual and reproductive rights, as well as to regulate abortion in line with the laws of some states, such as Tunisia.[11]

Abortion in Lebanon cannot be studied without first understanding the country's political and socioeconomic conditions. Since the end of the civil war in 1990, Lebanon has been highly characterized by political crises, systematic public corruption, and governmental disengagement from social problems. The population's most basic human rights (medical care, food and shelter, education, and employment) are not being met, and social and gender inequities are commonplace. This is the context in which women's rights organizations currently operate in Lebanon. These organizations' main aims have been to protect women against gender-based violence, advocate for the right of Lebanese women to grant their nationality to children and foreign husbands, and address the flaws of the personal status laws (especially those related to divorce and child custody). Abortion has yet to be tackled as a major reproductive health right.

Method

I conducted my qualitative study in the five

mohafazat (provinces) of Lebanon (Beirut, Mont-Lebanon, South-Nabatiyeh, North, and Bekaa). I collected data during a six-year period (2003–2008) through semi-structured face-to-face interviews (with the exception of one phone interview) with women who have had an abortion and physicians who offer abortion services. My interview guide for women focused on the following themes: (1) the context of their discovery of their pregnancy; (2) their decision to have an abortion; (3) support received from others; (4) their search for a physician; (5) their interactions with physicians; (6) accessibility to medical care; (7) secrecy management; and (8) their personal experiences of abortion. My semi-structured questionnaire for physicians was based on the following themes: (1) reasons for agreeing to perform an abortion in a clandestine context; (2) cases encountered; (3) how women formulated their requests for an abortion; and (4) precautions and secrecy management.

I recruited participants through personal networks I had fostered during my 10-plus years of work in the development sector, as well as through snowballing. This represents both the strength and the limitation of my study: while close relationships of trust gave me unique access in a clandestine context, they also resulted in a biased sample, which does not allow me to generalize my findings to the entire Lebanese population. All participants gave their informed consent and are anonymized in this article to ensure confidentiality. Interviews were conducted in Arabic and lasted between 45 minutes and three hours. Ethical concerns were addressed by the study protocol set under the supervision of my advisor within the context of my PhD dissertation.

Sample characteristics

The sample includes 84 women (ages 18–65 at the time of the interview) and 35 physicians. The physicians interviewed were all gynecologists who offered abortion services and were located in Beirut (11), Mont-Lebanon (8), South-Nabatiyeh (6), North (5), and Bekaa (5). They included 29 men and 6 women (ages 34–60 at the time of the interview) and included members of the following sectarian communities: Muslim (9 Sunnī, 9 Shīʿī, and 4 Druze) and Christian (14).

In sampling the women who had obtained an abortion, I took the following factors into account: (1) religious/sectarian community (Sunnī, Shīʿī, Druze, or Christian); (2) geographic region; (3) socioeconomic background; and (4) marital status. This theoretical sampling allowed for an intersectional analysis of women's access to abortion. In Lebanon, religious views related to the permissibility of abortion are diverse. Jurists of the Hanafi branch of Islam (followed by most Lebanese Sunnī Muslims) allow abortion at any time during the first four months of pregnancy (the period prior to "ensoulment").[12] For the Lebanese Shīʿī, abortion is also allowed (at any time during the pregnancy) to save the life of the pregnant woman. Druze and Christian religions do not permit abortion under any circumstances. Research on access to safe abortion suggests that socioeconomic background (often reinforced by an urban-rural divide) is also an important determinant. Women with fewer economic resources are therefore at a higher risk of seeking a less safe abortion.[13]

The most important attribute affecting the way women experience abortion in Lebanon is marital status. The sample of single women included 26 Muslims (12 Sunnī, 12 Shīʿī, and 2 Druze) and 15 Christians located in Beirut (13), Mont-Lebanon (8), South-Nabatiyeh (6), North (6), and Bekaa (8). This sample included different variations of being socially (and legally) considered "single" or "unmarried": women who have never been married; women who have concluded the *kitab*, which is the formal religious engagement preceding the wedding ceremony; women who have had a "temporary marriage"; and (iv) divorced women. (Temporary marriage is practiced within the Shīʿī community in Lebanon and is a contract between a man and an unmarried woman permitting sexual relations for a fixed amount of time.[14] It does not require witnesses. At the end of the agreed-on period, the temporary marriage automatically terminates without any divorce procedure. This contract liberates the individuals involved from religious guilt, but not fully protecting the woman socially. The Lebanese state does not forbid temporary marriage

but it also does not recognize it, and it is also not accepted by all members of the Shīʿī community.) The common characteristic among all of the single women interviewed was that their single status put them in a vulnerable situation when seeking an illegal abortion because their pregnancies were attached to stigma and shame.

The sample of married women included 26 Muslims (10 Sunnī, 10 Shīʿī, and 6 Druze) and 17 Christians. They were located in Beirut (12), Mont-Lebanon (7), South-Nabatiyeh (10), North (6), and Bekaa (8).

Data analysis

I analyzed data using the grounded theory, whereby data collection and data analysis are conducted in parallel.[15] I drew concepts out of each interview and then categorized them. I then performed a comparative analysis and axial coding. My analysis of patterns within the data yielded the two categories explored here: decision making and accessibility to safe abortion services.

Results and discussion

Inspired by Anselm Strauss's theory of negotiated order, I conceptualized decision making and accessibility to safe abortion services as moments of negotiation.[16] Throughout the process of discovering the pregnancy and deciding to terminate it in a clandestine manner, women negotiated with their partners, allies, and physicians in order to have access to safe abortion. Following from Strauss's theoretical perspective, the decision to terminate the pregnancy is not predetermined but rather the result of a negotiation where women and physicians create, maintain, transform, and are constrained by the illegality and social status of abortion. My intersectional analysis shows that religious affiliation has little impact on this negotiation, while marital and socioeconomic status are the most important determinants in negotiating access. Unmarried women from lower socioeconomic backgrounds are the most vulnerable, but even this group is able to access safe abortion services in medical clinics.

Decision making: Negotiation with the partner

For most of the women I interviewed, the decision to terminate the pregnancy was not made in isolation from their partner. In fact, it was largely dependent on the partner's decision to marry and assume paternity (in the case of single women) or to agree to the abortion (in the case of married women).

The most important element in all single women's trajectories was the nature of their relationship with their partner. Among those who were in a stable relationship, 7 continued the relationship and got married, while 26 ended the relationship following the illegal abortion. The seven women's reasons for seeking an abortion related mainly to finance, education, and the desire not to start childrearing at that precise moment. For women who wanted to continue the pregnancy, the possibility of an induced abortion was a source of conflict within the couple because their partners wanted them to terminate the pregnancy.

For the 26 women who ended their relationships, negotiations with the partner were crucial. They initially tried to convince their partners to marry them. They wanted to proceed with the pregnancy but were nevertheless faced with the partner's rejection, which then prompted them to resort to illegal abortion. The women's confrontation with their partner about the pregnancy, the decision of the partner regarding marriage, and the decision to terminate the pregnancy (or not) were key moments of negotiation. The discovery that the partner was not really committed to the relationship and did not have the woman's welfare as the primary concern was a painful process.

For example, 21-year-old Massa had been engaged to her partner for eight months. At the moment when she discovered that she was pregnant, she and her partner had already bought a house and were in the process of furnishing it. They had yet to set a marriage date. She recalled:

> *He told me he would think about it [the pregnancy and the need to get married as soon as possible]. After two days, without any response from him, I called him. He asked me to get rid of the fetus. I cried a lot, I begged him. ... He replied, "I do not*

know, I'm not even sure the child is mine." I was depressed. I did not understand what he was saying, that the child was not his. Then he told me, "Maybe you cheated on me." I decided to have an abortion because my fiancé did not trust me. ... It was agreed that the fetus should not be kept, that he should accompany me to the physician and that he himself should pay for the operation. He knew I didn't have money and as soon as I had some money, I used it to buy things for the house.

Her partner, meanwhile, was rushing her to have an abortion because he did not want to lose face socially. Massa did not break up immediately, since her partner was an important ally in helping her access an illegal abortion. However, the relationship ended shortly after the procedure.

Another respondent, 36-year-old Nada, had an abortion a year before our interview. She had been hoping to marry her partner and give birth to their child, but these hopes were in vain. She described her turmoil:

I was completely lost. He called a physician, his friend. He told him that he knew a close person who has a problem, who is not married, and who needs to have an abortion. He did not even tell him that it concerned him personally. ... I called the physician on his mobile. I was crying. I could barely articulate my words. He set an appointment for me. I went there. ... When I arrived at the clinic, I said to myself, "I have to be strong, I should not cry." But as soon as the physician asked me what was happening, I started to cry. This is the time I cried the most in all my life! I cried over my wasted life. I could not even breathe. I remember crying like that once when I was five years old because someone hit me. The physician told me that it did not matter and that he had many such cases, that sometimes even the girl was still a virgin. I was still crying. I was in the waiting room. The secretary was sitting at her desk. She was an old woman, small in size. She said to me in a reassuring tone, "It's nothing, it's nothing, do not worry. It's really not worth it." It helped me a lot. This is the only support I have had in this whole experience.

Partners are also an important ally for married women. Unlike the single women I interviewed, only a minority of married women (six) terminated the pregnancy against their choice. These women were pressured into an abortion by their husbands or families. The majority of married women, however, wanted to terminate the pregnancy. This group includes three main subgroups: women who already had at least one child and who did not plan for the additional child (they invoked reasons of birth spacing, finances, advanced age, and disagreement with their husbands); women who had no children and who did not want to have any at that particular moment (they invoked reasons of finances and a desire to pursue their education); and women who had gotten pregnant within the context of an extramarital relationship.

Rowayda was 35 years old, had been married for 18 years, and had four children. She explained the circumstances of her decision to have an abortion:

I did it because, thank God, I have four children. My house is very small. I have two rooms, one for my children and another for me and my husband. Financially, we are not so comfortable. And I have two children not so old; the nine-year-old and seven-year-old exhaust me a lot. I did not need one more child. I needed rest. When the operation was over, I was relieved. Before the operation, I felt a burden on my heart. I was desperate. I had two cases of death in the family. My mother and sister had died recently. I had a depression. ... I was relieved after the operation.

Souheir was a 43-year-old teacher who had been married for 17 years and had daughters aged 8, 10, 13, 14, and 16. She always wanted to have a boy. She recalled:

I felt that I was carrying a burden on my back, I was afraid of the pain because it was the first time I had an abortion ... the physician was understanding and kind, I was comfortable in his clinic. I did not feel anything during the operation. ... I felt relieved, but I was bothered by the fact that it might have been a boy.

Her husband was at home when she returned:

When I came back home, he said to me, "Thank God you are safe!" And he started crying. So, I cried with him. ... He thought like me, that maybe it's a boy, many times, he wanted a boy. ... At the time of the operation, I did regret it. But it's over.

> *... Sometimes I think about it when it comes to my mind, but I stop immediately.*

Marital status is an important determinant in women's decision-making process. Whereas most of the single women who were in a stable relationship wanted to continue with the pregnancy, they felt forced or pressured by partners to undergo an illegal abortion. These women ultimately made the decision to abort to avoid the stigma of single motherhood. The married women who terminated their pregnancies had a variety of reasons for doing so. However, in both groups, the decision to proceed with the pregnancy was clearly not the women's decision alone.

Negotiating access to safe abortion services

Allies who help women find a physician. Explaining their pregnancy (and consequently their sexuality) is a burden experienced by many single women seeking an abortion. Their pregnancy constitutes a confirmation of a sexual relationship; both of these elements (or at least the pregnancy) have to be kept secret to avoid stigma. In fact, these elements form an important part of a single woman's negotiation with her allies and later her physician in terms of presenting her case for an illegal abortion.

Married women may already have access to a gynecologist, but most single women do not and therefore must rely more heavily on their networks and social capital to access safe abortions. Compared to their single women counterparts, married women interviewed were more at ease in asking for help and disclosing their situation to a range of allies. It was only when their regular physician refused to induce an abortion that married women truly relied on the help of relatives or friends to access safe abortion services. In contrast, single women had to choose their allies with great care in order for their secret (sexual relationship and/or pregnancy) to be kept confidential.

These women's networks were based on kinship and friendship. For example, single women might ask a family member or friend to help them find a physician who would perform an abortion. Family members who became allies most often included the woman's mother, sister, or sister-in-law. Allies outside of the family included friends and work colleagues who were aware of the existing relationship. The women describe these allies as "true friends."

For example, 23-year-old Salma had an abortion three months before our interview. She described the support provided by a friend who was a nurse:

> *Initially, I wasn't aware of anything, I was feeling dizzy. I asked my friend; she told me that I had to do a pregnancy test, that maybe I was pregnant. We bought the test—she bought it. I was afraid to go to the pharmacy. ... My friend found the doctor, she talked to him. She explained my situation to him, she talked to him and made an appointment.*

Salma trusted the physician because she trusted her friend. After the operation, Salma stayed overnight at her friend's house. She explained:

> *She did not blame me. ... She is the only one who knows my story. She is the only person that I trusted and she helped me in everything. I just told her and she offered her help.*

Aya, a 23-year-old divorced woman, had entered a temporary marriage. She did not have children from her first marriage. After her divorce, she lived with her parents in her village. She had an abortion seven or eight months before our interview. Her sister helped her find a physician. Now remarried (to a different partner), Aya recounted her experience:

> *I told my sister. I told her everything. My sister and I are very close friends. She's married. At first she was shocked. ... I stayed at my sister's house all the time. My brother-in-law was not aware of anything [surrounding my circumstances]. He comes home late in the evening. Every day, I used to ask my sister if she had managed to find a doctor. The doctor that I usually go to knows her husband; she was afraid he might tell him. We had to find another doctor. Honestly, I do not trust anyone else; your sister will support you more than anyone else. If something happens to you and people start talking about you, it's as if they are talking about her, while your friend will leave you in a second. ... When I*

entered the clinic, I was afraid of dying ... I hugged my sister, and I begged her, "Take care of yourself and your children, and give mom a big hug for me ... and please do not tell her how I died." ... My sister started crying.

Physicians' gatekeeping role: Negotiating "fault" and "morality." Physicians who offer abortion services do not want to face legal problems later on and do not want to be recognized as physicians who offer abortion. Marwan, a physician from Beirut explained:

Sometimes the girl's father or someone else files a complaint against the doctor. It doesn't happen frequently, but it does happen. We cannot fully give our trust. ... Some colleagues have had problems. They helped a woman, and the next day the father or a family member threatened to sue them.

Physicians' consent to perform the procedure is based on their personal assessment of the woman's situation, especially her marital status, and the circumstances surrounding her pregnancy. The physicians I interviewed mentioned taking the following factors into consideration for single women: (1) the possibility (or impossibility) of marriage and (2) the stage of the pregnancy. Majed, a physician from Mount Lebanon, stated:

At the beginning I used to refuse. Later on, I accepted doing the operations because the patients were doing self-medication.

The majority of physicians (26) used the term "fault" in describing the situation that single women were in because of their illicit sexual relationships. Hyam, a female physician from the South, said:

Once a girl arrived. She came from school. She was carrying her schoolbag. ... She was 16 to 17 years old. I knew her mother, a decent person. ... She told me, "Auntie, it has been two months since I haven't had my period." ... I explained to her that she was pregnant. She was terrified. She begged me to help her. She told me that her mother could kill her. You feel she's like your daughter. I made her cry a lot. I do not want her to have other sexual relationships. Sometimes I meet her at the market. She lowers her head. She feels ashamed.

The degree of the pregnant woman's "fault" is the point of departure for negotiation for most of the physicians. As soon as an unmarried pregnant woman enters a physician's clinic, she must provide an account of her behavior, especially if she is young. She must often admit to having made a mistake (the sexual act), but the circumstances surrounding the relationship may help mitigate the perceived "fault." According to the physicians I interviewed, the most commonly used argument by these women is that they loved a man who promised her marriage and then abandoned her. The woman presents herself as a double victim: the victim of the man she loved and the victim of her own naivety and love.

Some physicians even suggest hymenoplasty to women to restore their virginity and thereby increase their marriage prospects after the illegal abortion. For example, Diana, one of the women I interviewed, said that her physician called her a few months after her abortion and offered to perform a hymenoplasty free of charge:

I refused. She asked me why. I told her that I was against this idea. She told me that she herself was against it, but that if I wanted she would do it.

All physicians I interviewed stated that if the partner is present and seems committed to the relationship, they try to convince the couple to get married. Some even recommend that the partner declare that the newborn was born at seven months instead of at nine months to suggest to the public that the pregnancy occurred after the marriage, and some physicians will even leave a newborn in the hospital incubator for one or two days to give the impression of a premature delivery. In such cases, physicians are acting as moral gatekeepers by preserving social norms related to the expectation that women should not engage in sexual activity before marriage.

For married women who have many children, physicians who are aware of the impact of socioeconomic conditions are often willing to terminate the pregnancy. In addition, if a married woman becomes pregnant by a man other than her husband (six physicians cited this situation), physicians will

also perform the operation to preserve the marriage. However, physicians, out of fear of possible legal consequences, will generally refuse to induce an abortion if there is disagreement within the couple.

Thus, physicians also operate as moral gatekeepers to preserve social norms related to married women's role in reproduction. Physicians indicated that they do not terminate the pregnancies of all women who approach them. Rather, they make their own moral choices based on the circumstances of the pregnancy and the woman's relationship with her partner. Interestingly, religious identity does not affect this "moral" decision making, since physicians of all major religious denominations offer abortion services, in spite of the fact that the permissibility of abortion varies according to the different religions. However, some physicians must separate their role as a doctor from their religious beliefs, while others are able to reconcile the two. Of the physicians I interviewed, the Sunnī and Shīʿī ones were able to reconcile their religious beliefs and the practice of abortion, while the Druze and Christian ones, recognizing that abortion is not allowed in their religion, had to separate their role as physicians from their religious beliefs.

Financial constraints. Socioeconomic background limits access to safe abortion because the price of a clandestine abortion can be very high. In Lebanon, the price of an illegal abortion varies between US$150 and US$2,400. A number of factors determine the cost: the physician's status (that is, credentials and reputation), the location of the medical clinic (urban versus rural and economically privileged versus disadvantaged neighborhood), the client's financial means, and characteristics of the demand (for example, early versus late pregnancy). Considering that the minimum wage set by the government is only US$633 per month, for some women, the cost of an illegal abortion is almost insurmountable.

In the midst of emotions such as fear of the operation, regret, guilt, fear of punishment, and relief, women must consider the financial cost of the abortion. Here too, marital status and socioeconomic background are important determinants.

Of the women I interviewed, married women from the middle and upper classes were more often able to have an abortion in a hospital setting because they were affiliated with health coverage schemes (for example, the National Social Security Fund or private insurance plans). In those cases, the abortion would be registered in the medical files as a miscarriage. Married women from disadvantaged socioeconomic backgrounds who did not have access to health insurance often had to seek an illegal abortion at a private clinic.

Feyrouz was a 42-year-old woman who had been married for 13 years. She had three children, ages 3, 11, and 12. She had undergone two abortions, and explained her first:

> *I got pregnant before having my youngest daughter. … I told my husband, and he did not allow me to keep the fetus because he was unemployed. … I told my story to the pharmacist. He sold me a medicine and told me to put two tablets in my vagina. I put two tablets and started bleeding. We were scared. My husband accompanied me to my physician. He [the physician] blamed me. … I had consulted him before to ask about getting an abortion, but he had refused, so that's why I consulted the pharmacist. … [The physician] did the operation without anesthesia.*

She then recounted her second abortion:

> *I was afraid of a second hemorrhage. I contacted my physician and told him that I had taken the pregnancy test and that the result was positive. I informed him that if he was not going to do the abortion, I would take the same medicine. So he gave me an appointment at the hospital. I went to the hospital, and my husband accompanied me to formalize all necessary papers, since I was insured by the National Social Security Fund. The physician did not say that it was a voluntary abortion but an abortion because of bleeding.*

However, most single women cannot seek an illegal abortion through their health insurance or their family physician because doing so would expose their double secret of the sexual relationship and (or at least) the pregnancy, thus causing them shame. They therefore must seek a clandestine abortion at a private clinic. The cost sometimes constitutes a

huge burden.

For example, Nawal, a 23-year-old, had an abortion about a year before our interview. She had to secure the funds in a way that was at odds with her ethics and morals. She explained:

> *My friend took me to a physician she knew. She made the appointment for me. Everything was already set. She said, "Don't worry. Just bring the money." She took care of everything; she spoke to me, then spoke to the physician. … The price was a big problem. At the first visit, I did not have money. When he set the date for the next day, I had not looked for it yet. I did not even have US$10 of the US$400 he requested. Imagine that I had to steal: Mom had a golden bracelet. I stole it to secure the money.*

Marital status and socioeconomic background are important factors in determining women's access to safe abortion in the clandestine context of Lebanon, with single women from disadvantaged socioeconomic backgrounds standing out as the most marginalized.

Conclusion

In contrast to women in other developing countries with restrictive abortion laws, women in Lebanon are largely able to access safe abortion services in medical facilities. Nonetheless, access to safe abortion is not a right but a privilege, with access hinging on a woman's ability to negotiate with partners, allies, and physicians. The process of negotiating access to safe abortion reinforces socioeconomic inequalities and patriarchal structures that constrain women's options. Against the legal backdrop of a state that denies women basic citizenship rights, women cannot make this crucial decision about their reproductive lives without first getting a green light from their partners, who hold an upper hand in the decision-making process. Whether or not single women continue with a pregnancy depends largely on their partners' willingness to marry them. Meanwhile, married women must negotiate with their husbands when deciding whether to continue a pregnancy, thus making the decision one based not only on the woman's personal choice but also on factors such as the family's financial situation.

Physicians play both a medical and a social role in offering abortion services. They allow women to negotiate access to abortion only under certain circumstances, which are almost always in line with prevailing social norms related to preserving the institution of marriage. Without a husband's consent, most physicians will not perform the operation unless the pregnancy results from an extramarital relationship.

On October 17, 2019, anti-corruption protests erupted throughout Lebanon. The grassroots movement gained momentum and called for a revolution (*thawra*). Women have been at the forefront of these protests, and sexual and reproductive rights are on protestors' agenda, making the possibility of social change in the near future a real one.

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References

1. *K. Afamia, A. Hassan, M. Khatoum, and E. S. Maya, "Abortion in Lebanon: Practice and legality," Al-Raida 99 (2002), pp. 55–58.*

2. W. M. Bickers, "Induced abortion in Lebanon," *Lebanese Medical Journal* 23/5 (1970), pp. 467–470.

3. Republic of Lebanon Ministry of Public Health, *Statistical bulletin 2014* (Beirut: Ministry of Public Health, 2014). Available at https://www.moph.gov.lb/en/Pages/0/10334/g-maternal-neonatal-mortality-notification-system-mnmn-.

4. L. Zahed, M. Nabulsi, and H. Tamim, "Attitudes

towards prenatal diagnosis and termination of pregnancy among health professionals in Lebanon," *Prenatal Diagnosis* 22/10 (2002), pp. 880–886.

5. T. Arawi and A. Nassar, "Prenatally diagnosed foetal malformations and termination of pregnancy: The case of Lebanon," *Developing World Bioethics* 11/1 (2011), pp. 40–47.

6. Ibid.

7. See L. Tønnessen and S. al-Nagar in this special issue.

8. See Office of the United Nations High Commissioner for Human Rights, *UN treaty body database*. Available at https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Treaty.aspx?CountryID=96&Lang=EN.

9. D. Dabbous, "Legal reform and women's rights in Lebanese personal status laws," *CMI Report 2017* (Bergen: Chr. Michelsen Institute, 2017), p. 3.

10. Committee on the Elimination of Discrimination against Women, Concluding Observations: Lebanon, UN Doc. CEDAW/C/LBN/CO/4-5 (2015).

11. United Nations Population Fund, United Nations Development Programme, and UN Women, *Gender-related laws, policies and practices in Lebanon* (2018). Available at https://lebanon.unfpa.org/en/publications/gender-related-laws-policies-and-practices-lebanon.

12. O. Bakar, "Abortion: III. Religious traditions: D. Islamic perspectives," in S. G. Post (ed), *Encyclopedia of bioethics* (New York: Macmillan Reference, 2004), pp. 39–43.

13. See E. Prada, I. Maddow-Zimet, and F. Juarez, "The cost of postabortion care and legal abortion in Colombia," *International Perspectives on Sexual and Reproductive Health* 39/3 (2013), pp. 114–123.

14. S. Haeri, "Temporary marriage," in J. D. McAuliffe (ed), *Encyclopaedia of the Qur'ān* (Washington, DC: Georgetown University, 2017 Supplement).

15. B. G. Glaser and A. L. Strauss, *The discovery of grounded theory: Strategies for qualitative research* (London: Routledge, 2017).

16. A. Strauss, L. Schatzman, R. Bucher, et al., "The hospital and its negotiated order," in E. Freidson (ed), *The hospital in modern society* (New York: Free Press, 1963).

Non-marital Pregnancies and Unmarried Women's Search for Illegal Abortion in Morocco

IRENE CAPELLI

Abstract

Abortion in Morocco is illegal except to safeguard a woman's life or health. Morocco has put some sexual and reproductive health policies into motion that are in line with the standards defined by the World Health Organization and the United Nations Population Fund, especially after the 1994 International Conference on Population and Development, but Morocco's Penal Code continues to criminalize the practice. This paper explores how proposed reforms to the abortion law that on the surface seem to legalize abortion in cases of severe health disorders or rape in reality moralize abortion, since vulnerable women should prove these conditions through lengthy bureaucratic procedures. Drawing on ethnographic fieldwork on unplanned pregnancies, I examine the social and health inequalities surrounding illegal abortion. My results show that socioeconomic status, education, geography, and marital status all play a role in delineating which women are willing or able to obtain an abortion and under which conditions the abortion takes place. I use the concept of "reproductive governance" to examine the relevance of rights-based approaches in Morocco, ultimately arguing that the intersection of socioeconomic and political processes in the country normalizes the risk and occurrence of illegal abortion, particularly for unmarried women living in precarious socioeconomic conditions, who are not addressed by sexual and reproductive health policies.[1]

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Introduction

In this article, I explore the issue of abortion in Morocco from an anthropological perspective. First, I discuss it in relation to the wider sexual and reproductive health and rights background of the country. Second, I situate it in the context of illegality, due to its current criminalized status. Finally, I look at it from the point of view of unmarried women who have had or have attempted to have an abortion.

I analyze the issue of abortion in Morocco by drawing on a growing body of anthropological debates that examine how struggles for human rights intersect with processes of "reproductive governance."[2] Scholars and other advocates argue that there are competing ways to claim and appropriate rights relating to reproduction and abortion.[3] The issue of abortion in Morocco is captured through the concept of "reproductive governance," which is "the mechanisms through which different historical configurations of actors—such as state institutions, churches, donor agencies, and nongovernmental organizations (NGOs)—use legislative controls, economic inducements, moral injunctions, direct coercion, and ethical incitements to produce, monitor, and control reproductive behaviors and practices."[4]

In this context, neoliberal development agendas often emphasize the responsibility of individuals for their lives, including in sexuality and reproduction. For example, governmental and nongovernmental programs may produce specific "regimes of care" for certain target categories of the population, and these regimes of care may be defined both by quantitative parameters (such as income) and in moral terms (such as a beneficiary's perceived vulnerability).[5] I address how NGOs engage in processes of "reproductive governance" by taking care of unmarried mothers. The perspective of reproductive governance as increasingly "influenced by global confluences that include elements of activism, finance, medicine, and humanitarianism" is central to my analysis.[6]

The paradigm of reproductive governance allows me to question the "configuration of actors" involved in Morocco's discourse on abortion, thus enabling the problematization of the normative boundaries of abortion, national sexual and reproductive health (SRH) policies, NGO programs targeting unmarried mothers, and women's experiences (especially those of lower-class, unmarried women).[7] This perspective informs my argument that even proposed reforms are likely to keep abortion in the realm of illegality. Abortion on demand is not a current prospect in the country, and even if proposed reforms were to take place, the termination of pregnancy would continue to be restricted to "sensitive" cases and would require women to comply with painstaking bureaucratic or medical procedures. Such procedures are arguably out of reach for many women due to family and economic constraints, as well as physical distance from health infrastructure.

I argue that reproductive governance unfolds in Morocco through a multiplicity of neoliberal and humanitarian policies that focus on individual responsibility—for example, programs aimed at assisting unmarried mothers by giving them shelter, health and social care, legal support, education, and professional training on the condition that they comply with certain standards of behavior, sexual conduct, discipline, and commitment to the organizations investing resources toward their "social reintegration."[8] I also claim that the Moroccan state's suspended partial legalization of abortion constitutes a peculiar form of reproductive governance, since the bureaucratic burdens of obtaining a "legal abortion" under the proposed reforms may have the perverse effect of incentivizing women to seek illegal abortions, thus normalizing this unsafe practice.

The background section of this article offers insight on the Moroccan legal and political framework. My research findings stem from ethnography on unmarried pregnant women in the country. Research on abortion in Morocco is politically and socially sensitive and thus has been largely neglected. Moroccan public institutions last collected data on abortion in 1995.[9] I conducted my ethnographic research on abortion practices in Morocco between 2011 and 2012, following preliminary fieldwork in 2009 and an investigation of abortion experiences of Moroccan women living in Italy in 2010.

In Morocco, female sexuality outside of mar-

riage is socially sanctioned, and extramarital sexual relations are criminalized under article 490 of the Penal Code.[10] Childbirth outside of marriage is also not legally or socially recognized, which means that the children of unmarried mothers are excluded from legitimate descent (*nasab*).[11] Although all women are affected by the illegality and potential risk of abortion, unmarried women face specific challenges to sexual and reproductive rights.

Literature on abortion legislation in the Middle East and North Africa touches on the issue of abortion in Morocco, as does the literature on youth sexuality and illegal abortion.[12] However, the issue of abortion has long been at the margins of socio-anthropological research on women's health and human rights. This article contributes to the existing literature by grounding its conclusions in extensive ethnography on SRH in Morocco and emphasizing the importance of subjective experiences and practices.

Abortion is an emblematic example of the structural challenges faced by Moroccan institutional and noninstitutional actors when attempting to implement sexual and reproductive rights in the country. By focusing on poor, young, and unmarried women who cannot afford safe (though illegal) abortions, I highlight the specific challenges faced by this group. Excluded from public SRH policies, these women embody a "legitimate vulnerability," a concept by which I refer to the fact that subjects (unmarried pregnant women and mothers) who defy the "legitimate" social order become socially acceptable and care-deserving so long as they can prove their vulnerability.[13] I simultaneously analyze the competing agendas of Morocco's legal framework on abortion and SRH policies, going beyond a narrow focus on either the legal, health, or Islamic perceptions of abortion and SRH. Further, I emphasize the controversial shift from a criminalizing to a moralizing discourse on pregnancy termination in Morocco that reflects broader humanitarian policies and ultimately normalizes illegal abortion while neglecting the issue of a woman's right to make choices about her body.

Over the last three decades, human rights and gender-based approaches have become "powerful signifier[s]"in Moroccan politics; however, such rights-based approaches are still largely contested or unacknowledged in relation to abortion and reproduction.[14] Further reflection on the political usefulness of concepts such as "reproductive rights" is needed, particularly that which considers not only the social, historical, and political context of these rights but also how these rights resonate with the experiences and views of affected individuals.[15]

Methods

I conducted field research in Casablanca over 10 months in 2011 and 2012. In particular, I examined NGO's efforts to provide care for unmarried mothers. Undertaking this research hinged on a wealth of bureaucratic procedures to gain approval and authorization. Because my university did not have an ethics committee at the time, I directly negotiated the possibility of engaging in ethnographic fieldwork with seven Moroccan NGOs, which authorized me to conduct my research through interviews, observations, and participation in their activities. Four of the NGOs explicitly targeted unmarried mothers, while the others included them among their target groups. This allowed me to meet women with diverse trajectories. None of the organizations had a focus on abortion, although some representatives of these organizations had publicly taken a stance on the issue and raised the topic with me individually as well as during group meetings with beneficiaries.

My main source of data came from interviews with beneficiaries of these NGOs. I interviewed about 50 unmarried women during their pregnancy or after childbirth. Most of the women came from middle to low socioeconomic backgrounds. Their educational levels were diverse, spanning from illiteracy to a bachelor's degree, although most had a medium to low educational level. Many had failed at attempts to self-induce abortion or were unable to access appropriate health care facilities due to time, distance, or financial barriers. Some of these women raised the issue of abortion immediately and discussed the topic openly, while others did not raise the issue at all in initial discussions with

me. Establishing rapport—both with the women themselves and with the professionals serving them—was crucial, and I have maintained relationships with many of my respondents over the years.

I also met with health professionals at public and nongovernmental health facilities (health centers, hospitals, and dispensaries). These included medical doctors (general practitioners, gynecologists, and pediatricians), midwives, nurses, psychologists, and psychiatrists. I contacted some of them via the NGOs that had authorized my research and others through academic contacts and previous fieldwork acquaintances. I also obtained academic agreements with Moroccan academic institutions and letters of introduction from Italian and Moroccan universities and research centers, which were useful in making contacts. I interviewed key informants in the fields of medicine, law, bioethics and Islam, abortion activism, and journalism in both Casablanca and Rabat. In addition, I talked to herbalists in Marrakesh and observed an abortion-rights-versus-anti-abortion-rights demonstration on the Mediterranean coast. Finally, I attended public initiatives and student meetings on abortion in Casablanca.

Reproductive health and rights in Morocco: Contested grounds and agendas

The idea of "reproductive governance" suggests that rationalities in the area of reproduction in Morocco—as elsewhere—may shift based on prevailing politics. It also raises a question of why the topic of abortion is so often absent from public discussions on SRH, rather being cast as an exception to the local political economy of health.[16] To address this gap, I shall outline the field of SRH and rights before illustrating the normative framework of abortion.

In 2018, expenses for "integrated sexual and reproductive health services" in Morocco included those targeted at "[i]ncreased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access."[17] This initiative involved US$668,239 in expenditures, of which 83% came from the United Nations Population Fund (UNFPA), 10% from NGOs, and 7% from the Moroccan government.[18] These figures do not include the costs of private health services, which contribute to stratifying health care asymmetries between rural and urban areas and between private and public services.

Major issues, such as systemic corruption, affect health and are addressed through reforms extending medical coverage to populations categorized as vulnerable or poor.[19] With regard to SRH, Morocco participated in a program of action approved by the 1994 International Conference on Population and Development, which guided the government in implementing SRH policies.[20] Currently, the notion of SRH is more widely used than that of "family planning," both by public health agencies and NGOs, suggesting that the country is shifting its approach from one of population control (adopted in the 1960s) to one of individual rights.[21]

Morocco made only limited progress in achieving Millennium Development Goal (MDG) 5, which focused on "improving maternal health," and MDG Target 5B, which aimed to "achieve by 2015 universal access to reproductive health."[22] Unsafe abortion was either not included or only briefly mentioned by Moroccan institutions in reports on the achievement of the MDGs and by WHO reports focusing generally on target B of MDG5 (without a country-specific focus).[23] It is also not addressed in the 2012–2016 UNFPA country program, despite that program's emphasis on SRH as a core component.[24] In Morocco, abortion is mostly practiced illegally; therefore, official public health data is not available.

The affirmation of SRH rights seems contentious in Morocco, as demonstrated by the difficulties that women in rural communities face in accessing reproductive care. Rural regions have historically been marginalized by the state and suffer from a chronic lack of health care infrastructure, especially for childbirth.[25] Even when they are available, as in the cities, these services overwhelmingly target married women and are difficult or even impossible for young, unmarried people to access.[26] Public

primary health centers that provide SRH services are mostly located in low-income neighborhoods, and unmarried women and men rarely access them for consultations, contraception, or HIV screening or prevention due to widespread social stigma surrounding these issues.[27] In large part, this is because non-marital and non-reproductive sexuality defies social norms of respectability (although this view also depends on socioeconomic status).[28] For example, although contraception is available through public health centers and NGO clinics (such as the Moroccan Association for Family Planning), unmarried individuals may not feel socially safe accessing these venues. Women with financial means pay for private practitioners for perceived confidentiality reasons, although these practitioners are not always available. Contraceptive pills and emergency contraception can also be bought at pharmacies.[29]

Discourses about SRH rights and policies coexist with article 490 of the Penal Code, which sanctions sexual relations outside of wedlock. Thus, the Moroccan state fosters global notions of SRH that may collide with its own laws and with Islamic behavioral prescriptions. Such competing agendas must be understood in the context of the post-independence growth of Morocco's young and unmarried population, following demographic transition and socioeconomic changes (including urbanization, salaried work, the postponing of marriage, and transnational migration).[30] Some centers run by the Moroccan Association for Family Planning—mostly in urban areas—have adjusted to this changing social landscape by offering youth-centered services and educational activities.[31] Various NGOs nationwide also work on SRH issues. In short, multiple public and nongovernmental actors intersect in providing SRH services.

In particular, I have analyzed how unmarried mothers have been identified either as a specific target for intervention or as part of a broader target by Casablanca-based NGOs, which has led to the emergence of "unmarried mothers" as a social category in the public space and the context in which they and their children receive care. Notably, over the last three decades, some NGOs have transformed the significance of certain social groups, meaning that some women who are experiencing both material and social distress (including children born out of wedlock) have "become" vulnerable categories and new targets for humanitarian action.[32] If a woman can prove she is "vulnerable," as defined by the NGO, she can access certain services—including SRH services—either at the NGO itself or through public and private service providers that collaborate with them as volunteers or benefactors. Although the process of assessing eligibility for services is purportedly meant to combat gender and sexual stigma, in reality, this process may be embedded in a compassionate framework that does not actually "redress injustice."[33] More importantly, the fact that women who can prove their eligibility are able to access SRH services through NGOs does not resolve the larger issue of the lack of free, good-quality SRH services for all women, regardless of their status. This seems at odds with the positioning of these services within a social justice framework.

Ultimately, this creates a paradox of claiming vulnerability over rights. Beneficiaries of the health, social, and sexual rights afforded by NGOs must prove certain conditions in order to be temporarily entitled to care, such as being a first-time mother, being at risk, experiencing distress, facing rejection by family, or demonstrating personal capabilities such as self-discipline and participation. This neoliberal provision of care is thus based on individual responsibility and, accordingly, "re-moralizes" sexual conduct.[34] I argue that it is worth considering how vulnerability is constructed in these policies and in the proposed legal reforms to Morocco's abortion law, as well as in current debates on sexual and reproductive rights.

Legal framework and the suspended abortion law changes

Islamic jurisprudence (*fiqh*) in Morocco follows the Maliki School, which completely forbids abortion. However, the final declaration of the 1971 Rabat Conference on Islam and Family Planning forbids abortion after the fourth month unless the mother's

life is in danger, suggesting that the view of Islam on abortion may vary.[35] Such differences in doctrinal beliefs about abortion have become important in politics, as some actors consider Islamic law as a reason to oppose the practice, while others use such jurisprudence to claim that abortion may be licit.

Nonetheless, the legacy of colonial laws in codifying an anti-abortion stance in current legislation outweighs any potential flexibility of interpretation.[36] For example, chapter 8 of the Moroccan Penal Code, titled "Crimes and Offences against Family Order and Public Morality," provides that abortion is legal if it aims to preserve the woman's health and is practiced within the first 120 days of gestation by a physician *and* with the husband's authorization.[37] When there is no husband, or if the husband cannot or will not authorize an abortion, the responsible physician must obtain authorization from the chief medical officer of the hospital. The Penal Code also provides that abortion is legal to save a woman's life (in which case spousal consent is not required), but another physician must be consulted before the procedure is performed.[38] In short, abortion always hinges on complicated bureaucratic procedures. Other articles establish imprisonment and fines as sanctions for inducing and publicizing abortion.[39]

In 2015, the king of Morocco asked the minister of Islamic affairs, the minister of justice and freedom, and the president of the National Council of Human Rights to conduct a national consultation on the issue of abortion involving local organizations, former ministers of health, justice, and the family, and experts in psychology, sociology, bioethics, law, and philosophy. The results paved the way for legal modifications, according to a royal release from May 2015.[40]

In June 2016, the Council of the Government adopted an initiative to reform Morocco's Penal Code (Project of Law No. 10-16).[41] The reform of articles regulating abortion was also included in this initiative, although the legislative process is currently on hold.[42] In April 2018, the Party of Progress and Socialism filed a bill to amend the Penal Code to legalize abortion on health grounds in more cases than the ones provided by the Project of Law No. 10-16.[43] The Moroccan Organization against Clandestine Abortion (AMLAC) expresses a similar view. Founded in 2008, AMLAC advocates for creating a "clear legal framework" for abortion in order to prevent morbidity and mortality (however, the organization does not espouse concepts such as "body ownership").[44]

The dynamics of local abortion politics and the effects of potential legal changes are noteworthy. Project of Law No. 10-16 envisages amending article 453 to permit abortion in more cases but would still limit abortion to cases of rape, incest, mental disorder, and serious fetal malformation. Even then, abortions would be allowed only under strict conditions. For example, in the case of rape or incest, abortion would be allowed if performed by physicians at a public hospital or authorized private clinic during the first 90 days of pregnancy. The woman seeking an abortion would need to provide a document authenticated by the royal public prosecutor showing that she followed a judicial procedure. Additionally, an officer of the relevant province or prefecture would need to be notified. Women would be required to spend three days in reflection, during which time they would supposedly meet with social workers who would inform them about alternatives to and medical issues associated with abortion.

These conditions would also apply in cases of "fetal malformation" (not defined in the proposal) and genetic pathologies.[45] However, for those cases, abortion would be allowed up to 120 days of gestation. The Ministry of Health would be tasked with creating medical commissions to elaborate on the examinations and tests required to certify the malformation or pathology. The same regulations would apply to a woman affected by a "mental disorder"; however, she would also be required to show authorization from her spouse, parents, or legal guardian. The National Council of the Order of Medical Doctors would be required to submit to the Ministry of Health a list of mental disorders for which abortion would be legal.[46]

The above conditions, regulations, certificates, and forms of proof construe what I call the "conditional legalization" of abortion in Morocco.

These myriad requirements are worth emphasizing because they would restrain women's access to safe abortions, especially for cases that are hard to disclose or prove. The media has improperly characterized this potential reform as "liberalization," but organizations such as the AMLAC do not intend it as such, instead advocating for the reform as a measure to prevent health and social risks.[47] The proposed bureaucratic procedures would govern not only abortion itself but also women's sexual and reproductive lives. It would be unimaginably hard to obtain all of the required documentation to receive an abortion, particularly within the timeframes provided.

Hence, even were these reforms to be adopted, they would not conceive of abortion as an individual right, and women would still be pushed to obtain illegal abortions. Indeed, the proposed reform dismisses the fact that some women might choose to interrupt their pregnancy for reasons other than those permitted by law. It assumes that women's bodies must perform their reproductive function, unless a woman has some higher moral reason to abort. A woman must prove that she is deserving of an abortion and that her claims are credible. This approach reinforces normativity and essentialism in gender roles and relationships.[48]

A major contradiction becomes clear from this analysis. On the one hand, international agencies proclaim the importance of reproductive health and (to a much lesser extent) globally conceived rights and use these claims when cooperating with Moroccan health institutions. On the other, official SRH agendas in Morocco tacitly exclude abortion rights, and laws continue to criminalize the practice as a crime against family order and public morality. These competing agendas and the ambiguities of law reform cannot but undermine any rights-based SRH policy.

Non-marital pregnancies and unmarried women's search for illegal abortion

Given that the reform initiative is currently on hold, it is impossible to know for certain how it would affect Moroccan women's experiences and push them toward illegal abortions. Therefore, my analysis below refers to the current framework, which has not changed since my fieldwork in 2011 and 2012. Nonetheless, even were the framework to change, it is likely that women who live in the most precarious socioeconomic conditions (and even those who do not) would rarely choose to go through all required procedures to claim the right to a legal abortion, regardless of whether they "fit" into one of the admissible categories.

The ethnographic material analyzed here concerns my research subjects' search for abortion providers (that is, clinics and practitioners), their abortion experiences, and sometimes their (attempted) abortions. These practices need to be understood by looking at women's ability to make decisions governing their lives, but often women do not or cannot make any decision. Women live their experiences within their social and relational configurations—in other words, within their "local moral worlds."[49] They draw on "practical moralities," and their attitudes are shaped by intersecting structural conditions (such as time, distance to facilities, and availability of practitioners), relational conditions (such as the support of a partner or family), and contingent conditions (such as money, transportation, and conflicting work or familial duties), which inform their scope of action and may even counter their intentions and desires.[50] A consideration of these aspects may shed light on whether a rights-based approach to SRH and abortion policies will resonate with women, and, ultimately, if it will substantially improve their lives.

AMLAC estimates that trained practitioners in Morocco perform several hundred illegal abortions each day. This is on top of abortions that women self-induce through nonmedical means. National and international estimates suggest the spread of illegal, yet systematic, abortion and indicate that illegal abortions occur irrespective of class, generational, and educational distinctions.[51]

For example, some women may be unable to raise money for an abortion in time to obtain one, even if they ask for assistance from friends and acquaintances. This is especially the case if the woman discovers her pregnancy late or if—for instance, due

to familial obligations—she has to move across the country and stops searching for abortion providers, thus allowing her pregnancy to progress. Visits home usually demand the use of one's savings for traveling and gifts, as well as hiding the pregnancy from family members. As Mouna said:

> I found it out early and I couldn't believe it. I agreed with my boyfriend to raise money to pay a doctor ... but it was not enough. In the meantime, I had to go home and see my family. When I came back and found a doctor, it was too late. I was told it was too big and [having an abortion] might have been dangerous.[52]

Others, living on precarious and underpaid jobs, cannot even envisage paying for the procedure and attempt to self-induce abortion in hazardous conditions. Traditional domestic methods may be their first or only abortion attempts; such methods include herbal concoctions that supposedly induce bleeding, combinations of certain beverages and aspirin or other drugs, certain spices, exposure to the smoke produced by burning specific herbs, overmedication, toxic substances, and mechanical practices. To date, recourse to misoprostol (commonly used to induce abortion) has not been documented in Morocco.[53]

When women are still not fully aware that they are pregnant, but fear early pregnancy, they might try some methods that are used to induce menstruation but that also have potentially abortive outcomes. When used, these methods might not be effective, and therefore many pregnancies are confirmed late.

Some women stated in interviews that they continued to bleed and thus discovered their pregnancies only when their bellies grew or they had other symptoms. Older women tend to recognize pregnancy earlier, but they may not be able to choose whether to continue it due to spousal authorization requirements, even in the clandestine abortion market. Public hospitals may also provide abortions if women arrive at the emergency room after inducing an abortion and describe the inducement as a non-intentional event.

Even when obtaining an abortion would be feasible in the illegal market, some unmarried women may decide not to obtain one for moral reasons, while others might not obtain one because someone else (perhaps a partner or other family member) convinces them not to intervene. These people may convince women to continue their pregnancies and to give the children up for informal adoption, sometimes to other family members. In addition, some NGOs strive to arrange the custody of these children through formal procedures. Other NGOs involve their beneficiaries in sex education activities to prevent subsequent pregnancies. These latter NGOs—according to their beneficiary selection criteria—actually exclude women from further assistance if they become pregnant again or if they have more than one child. In any case, young, unmarried women who attempt abortion do so within an uncertain relational scenario between the official and unofficial spheres. These different spheres ascribe different significance to pregnancy, its potential disruption, and the legitimacy of filiation.[54] For example, some young women may not consider abortion if they expect to marry the father, but may do so if the marriage prospect falls apart.

Absent or irregular menstruation leaves an ambiguous space for practices of menstrual induction, which may not be considered abortive according to local practices of fertility regulation.[55] In such cases, abortion results in juggling uncertainties or, in other words, "manipulating ambiguity."[56] The experience of a young woman known as Nawal is emblematic of such an understanding: she initially attributed her missing period to her irregular cycle and fatigue, but also started to suspect pregnancy. It also illustrates the challenges that women like her face when confirming pregnancy and in the search for pregnancy interruption within precarious relational and socioeconomic situations. Unmarried and living in a small town, Nawal discovered her pregnancy toward the fourth month and tried some potentially abortive mechanic and chemical methods. She explained:

> I tried everything ... nine aspirins, I ate lots of cinnamon and I did fumigations with that stuff I bought at the herbalist, but nothing worked. But it was expensive. Now I fear this could have been

> harmful for the baby. After that I drank Coke with aspirin again and I wore a very tight belt. My boyfriend would have even been able to pay the doctor [for an abortion] but it was too late and too risky.

Another interviewee from a poor neighborhood in Casablanca, 20-year-old Jamila, managed to have an abortion soon after she started seeking it. She was unmarried and engaged in multiple relations, in which sexual and monetary exchanges overlapped.[57] She discovered her pregnancy early on and wanted to terminate it, so her mother helped her find the money for a medical abortion in a clinic that her friends had suggested. Jamila stressed the diverse socioeconomic and marital statuses of the other patients and highlighted that abortions were systematic and just "normal," both for the well-off and for the disenfranchised. Although the experience was financially demanding, everything ran smoothly in her case and (because it was relatively easy to access the clinic) the boundaries of legality and illegality of this practice appeared to her quite blurred.

Boutaina had a different experience, which hints at the risks that women incur in the context of illegal abortions. Boutaina was an unmarried mother in her 30s and worked as a domestic worker for affluent families. After returning home from the private facility where she had her second abortion, she began to experience complications. She had not had complications after her first abortion, so the difficulties were unexpected. Boutaina might have died from a hemorrhage if a neighbor had not called the doctor who performed the operation, who promptly took her to a clinic. Nobody asked her to explain her story, and she was sent home once she recovered.

The experience of abortion is shared across generations of women. As stated by one 25-year-old, "My mother also had an abortion. ... Of course, she already had kids and could not bear more." This insight poignantly illustrates that the public debates, which raise abortion as a moral issue associated with extramarital sex and youth, do not take into account local realities and may therefore jeopardize abortion rights advocacy. Although I explore this question primarily from the point of view of women who have experienced pregnancy outside marriage, it would be misleading to assume an exclusive nexus between abortion and extramarital, "illegitimate" pregnancies and child abandonment.[58] Doing so would dismiss the fact that women seek abortions for an array of reasons. The construction of abortion rights arguments that associate abortion with "illegitimate" sexual relations, with specific medical conditions, or with socially sensitive situations—instead of claiming abortion as a right ascribed to *any* woman—reproduces the Penal Code's restrictive, moralizing logic.[59]

Conclusion

This article highlights the ambiguous status of abortion in Morocco by situating the issue against the background of reproductive health and rights. Since the 1990s, national and international agendas have espoused the importance of SRH policies. However, SRH policies in Morocco have yet to adequately address abortion, which is instead regulated by the Penal Code as a crime against morality, except in circumstances threatening the pregnant woman's life or health. Researchers and policy makers need to address these competing political agendas when analyzing what "reproductive governance" means in Morocco.[60]

This is particularly relevant in the context of proposed legal reforms, which would legalize abortion only on certain conditions and set forth restrictive and complicated bureaucratic procedures. This "conditional legalization" merely reinforces the structural barriers to legal and safe abortion. Notably, the logic underpinning the proposed reforms circumscribes abortion to specific medical or vulnerability cases. This legitimizes a "moral hierarchy of abortion" by allowing abortion in circumstances viewed as morally acceptable, while simultaneously neglecting that abortion is a reproductive right. The proposed legal changes focus on vulnerable targets who must struggle to comply with eligibility criteria for health and abortion care. Such potential reform seems actually coherent with Morocco's unequal health care system and the

neoliberal logic through which governmental and nongovernmental institutions provide health care services to individuals on condition of their ability to demonstrate that they deserve them.

Abortion is a tacitly acknowledged practice in Morocco, but it is becoming an increasingly debated political topic. However, the recent application of Morocco's anti-abortion law to a journalist who criticized the government casts a shadow on the prospect of meaningful law reform.[61] The recognition of abortion as a human right is contentious, and "tensions between how human rights are understood in supranational conventions and legal structures and how they are interpreted locally" must be acknowledged in any analysis.[62] Interestingly, the process that brought about the law reform initiative involved (among others) Morocco's National Council for Human Rights, which suggests that debates on abortion could be viewed as part of debates on human rights more generally. However, rights-based approaches to political change continue to ride on a shifting terrain of conflicting claims.[63]

As shown by the case of women experiencing pregnancy and abortion outside marriage, global concepts of sexual and reproductive rights as human rights do not seem to resonate with individuals' subjective experiences, including their relationship "to the law, the State and the medical sphere."[64] The individuals with whom I spoke shared stories that illustrated multilayered social and legal inequalities, gaps among health policies, and individual decision-making strategies. Nevertheless, each of these women had her own individual experience, and we cannot overlook the fact that women seek and experience abortion irrespective of marital, educational, or socioeconomic status.

Importantly, many women attempt abortion in unsafe conditions, due to their financial, temporal, geographical, and relational constraints. Most of them have experienced life-long social, economic, and educational inequalities that necessarily inform their reproductive and abortion experiences. Therefore, simply engaging in legal reform of abortion will not be enough. The social and political commitment to counter inequalities among women should be the ground for substantially affirming sexual and reproductive rights as human rights.

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References

1. L. M. Morgan and E. F. S. Roberts, "Reproductive governance in Latin America," *Anthropology and Medicine* 19/2 (2012), pp. 241–254.

2. Ibid.; J. Mishtal, "Reproductive governance and the (re)definition of human rights in Poland," *Medical Anthropology* 38/2 (2019), pp. 182–194; M. El Kotni and E. O. Singer, "Human rights and reproductive governance in transnational perspective," *Medical Anthropology* 38/2 (2019), pp. 118–122.

3. F. D. Ginsburg, *Contested lives: The abortion debate in an American community* (Berkeley: University of California Press, 1998); W. Nowicka, "Sexual and reproductive rights and the human rights agenda: Controversial and contested," *Reproductive Health Matters* 19/38 (2011), pp. 119–128; L. M. Morgan, "Reproductive rights or reproductive justice? Lessons from Argentina," *Health and Human Rights Journal* 17/1 (2015); Mishtal (see note 2).

4. Morgan and Roberts (see note 1).

5. M. I. Ticktin, *Casualties of care: Immigration and the politics of humanitarianism in France* (Berkeley: University of California Press, 2011); C. Hughes Rinker, "Creating neoliberal citizens in Morocco: Reproductive health, development policy, and popular Islamic beliefs," *Medical Anthropology* 34/3 (2015), pp. 226–242; I. Capelli, "Cibler les mères célibataires: La production bureaucratique et morale d'un impensable social," in I. Bono and B. Hibou (eds), *Le gouvernement du social au Maroc* (Paris: Karthala, 2016), pp.

199–232.

6. L. M. Morgan, "Reproductive governance, redux," *Medical Anthropology* 38/2 (2019), p. 114.

7. See Morgan and Roberts (see note 1); Ibid.

8. Capelli (2016, see note 5).

9. M. E. Gruenais, "La publicisation du débat sur l'avortement au Maroc : L'État marocainen action," *L'Année du Maghreb* 17 (2017), pp. 219–234.

10. Kingdom of Morocco Ministry of Justice, *Code pénal* (Rabat: Ministry of Justice, 2018). Available at http://adala.justice.gov.ma/FR/Legislation/textesjuridiques_penal.aspx.

11. J. Bargach, *Orphans of Islam: Family, abandonment and secret adoption in Morocco* (Lanham, MD: Rowman and Littlefield, 2002).

12. L. Hessini, "Abortion and Islam: Policies and practice in the Middle East and North Africa," *Reproductive Health Matters* 15/29 (2007), pp. 75–84; L. Hessini, "Islam and abortion: The diversity of discourses and practices," *IDS Bulletin* 39/3 (2008), pp. 18–27; F. Bakass and M. Ferrand, "L'entrée en sexualité à Rabat: Les nouveaux 'arrangements' entre les sexes," *Population* 68/1 (2013), pp. 41–65; A. Guillaume and C. Rossier, "L'avortement dans le monde: État des lieux des législations, mesures, tendances et consequences," *Population* 73/2 (2018), pp. 225–322. See also F. Roudi-Fahimi and S. El Feki, *Facts of life: Youth sexuality and reproductive health in the Middle East and North Africa* (Washington: Population Reference Bureau, 2011); A. Agnès, G. Agnès, F. Bakass, et al., "Decisions about unplanned pregnancies and abortion among women and men in Morocco and Senegal: Influence of norms, practices, and institutional contexts" (presentation at "Decision-making regarding Abortion: Determinants and Consequences," Strengthening Evidence for Programming on Unintended Pregnancy Research Consortium, Nanyuki, Kenya, June 2014). Available at http://www.documentation.ird.fr/hor/fdi:010064338#.

13. Capelli (2016, see note 5).

14. Morgan (see note 3).

15. Capelli (2016, see note 5).

16. S. Morsy, "Political economy in medical anthropology," in C. F. Sargent and T. M. Johnson (eds), *Medical anthropology: Contemporary theory and method* (Westport, CT: Praeger, 1996); Morgan and Roberts (see note 1); A. E. Yamin and P. Bergallo, "Narratives of essentialism and exceptionalism: The challenges and possibilities of using human rights to improve access to safe abortion," *Health and Human Rights Journal* 19/1 (2017), pp. 1–11.

17. UNFPA, *Key results of Morocco in 2018* (2018). Available at https://www.unfpa.org/data/transparency-portal/unfpa-morocco.

18. Ibid.; see also World Health Organization, *Current health expenditure (CHE) as percentage of gross domestic product (GDP) (%)* (December 11, 2017). Available at http://apps.who.int/gho/data/node.main.GHEDCHEGDP-SHA2011?lang=en/.

19. A. Akesbi, "La corruption endémique au Maroc," *NAQD* 25/1 (2008), pp. 41–66; B. Hibou and M. Tozy, "La lutte contre la corruption au Maroc: Vers une pluralisation des modes de gouvernement?" *Droit et Société* 72/2 (2009), pp. 339–357; Instance Centrale de Prévention de la Corruption, *Étude sur le phénomène de la corruption dans le secteur de la santé: Evaluation et diagnostic* (Rabat: ICPC, 2011); K. El Mesbahi, "La prévention de la corruption au Maroc, entre discours et réalité,"*Pouvoirs*145/2 (2013), pp. 83–97.

20. Haut Commissariat au Plan, "La santé de la reproduction dans la politique de population au Maroc," in *Démographie: Approche multi-sectorielle de la politique de population* (Rabat: HCP, 2005), pp. 174–241. Available at https://www.hcp.ma/downloads/Demographie-Approche-multi-sectorielle-de-la-politique-de-population_t13082.html.

21. F. Mernissi, "Obstacles to family planning practice in urban Morocco," *Studies in Family Planning* 6/12 (1975), pp. 418–425; Haut Commissariat au Plan, *Rapport national sur la politique de la population* (Rabat: HCP, 2004), http://www.hcp.ma/downloads/Demographie-Rapport-national-sur-la-politique-de-la-population_t13064.html; Hughes Rinker (see note 5).

22. See Kingdom of Morocco High Commission for Planning, *Morocco between Millennium Development Goals and Sustainable Development Goals: Achievements and challenges* (Rabat: Kingdom of Morocco High Commission for Planning, 2015). Available at https://www.hcp.ma/file/174377/.

23. Ibid.; see also World Health Organization, *Universal access to reproductive health: Accelerated actions to enhance progress on Millennium Development Goal 5 through advancing Target 5B* (Geneva: World Health Organization, 2011).

24. UNFPA, *Final country programme document for Morocco* (Geneva: UNFPA, 2011).

25. I. Capelli, "Risk and safety in context: Medical pluralism and agency in childbirth in an eastern Moroccan oasis," *Midwifery* 27/6 (2011), pp. 781–785; K. Zaouaq, "Les femmes et l'accès aux soins de santé reproductive au Maroc," *L'Année du Maghreb* 17 (2017), pp. 169–183. For a regional comparison, see I. Maffi, D. Delanoë, and S. Hajri, "La santé sexuelle et reproductive, champ d'exercice et d'affrontement des dominations de genre et de classe," *L'Année du Maghreb* 17 (2017), pp. 9–19.

26. Roudi-Fahimi and El Feki (see note 12); I. Capelli, "Les enjeux et les déclinaisons de la notion de 'santé sexuelle et reproductive' au Maroc: Réflexions à partir du cas des grossesses hors mariage," *L'Année du Maghreb* 17 (2017), pp. 83–99.

27. Capelli (2017, see note 26).

28. M. Cheikh, "De l'ordre moral à l'ordre social: L'application des lois pénalisant la sexualité prémaritale selon des lignes de classe," *L'Année du Maghreb* 17 (2017), pp. 49–67.

29. International Consortium for Emergency Contra-

ception, *EC status and availability: Morocco*. Available at https://www.cecinfo.org/country-by-country-information/status-availability-database/countries/morocco/#.

30. Y. Courbage, "Fertility transition in the Mashriq and the Maghrib: Education, emigration, and the diffusion of ideas," in C. Makhlouf Obermeyer (ed), *Family, gender and population in the Middle East: Policies in context* (Cairo: American University in Cairo Press, 1995); C. Makhlouf Obermeyer, "Sexuality in Morocco: Changing context and contested domain," *Culture, Health and Sexuality* 2/3 (2000), pp. 239–254.

31. AMPF, *Adolescents et jeunes* (Rabat: AMPF, 2014). Available at http://www.ampf.org.ma/index.php/87-axes/jeunes.

32. Capelli (2016, see note 5).

33. P. Farmer, *Pathologies of power: Health, human rights, and the new war on the poor* (Berkeley: University of California Press, 1999).

34. Capelli (2016, see note 5).

35. D. Atighetchi, "De la manière de considérer l'aube de la vie: Une comparaison entre droit musulman et droits des Etats musulmans contemporains," *Droit et Cultures* 59/1 (2010), pp. 305–329. Regarding views of Islam on abortion, see B. F. Musallam, *Sex and society in Islam: Birth control before the nineteenth century* (Cambridge: Cambridge University Press, 1983); D. L. Bowen, "Abortion, Islam and the 1994 Cairo Population Conference," *International Journal of Middle Eastern Studies* 29/2 (1997), pp. 161–184; M. Ghaly, "Human embryology in the Islamic tradition: The jurists of the post-formative era in focus," *Islamic Law and Society* 21/3 (2014), pp. 157–208.

36. Hessini (2007, see note 12).

37. Kingdom of Morocco Ministry of Justice (2018, see note 10), art. 453; Guillaume and Rossier (see note 12).

38. Kingdom of Morocco Ministry of Justice (2018, see note 10), art. 453.

39. Ibid.

40. Kingdom of Morocco National Human Rights Council, *Outcome of consultations on abortion submitted to the king* (May 15, 2015). Available at https://www.cndh.org.ma/an/highlights/outcome-consultations-abortion-submitted-king.

41. Kingdom of Morocco House of Representatives, *Project of law n. 10-16* (Rabat: House of Representatives, 2016). Available at http://www.chambredesrepresentants.ma/sites/default/files/loi/10.16.pdf.

42. G. Khadiri, "Les Marocaines attendent toujours la réforme de l'avortement voulue par Mohamed VI," *Le Monde* (March 18, 2018). Available at https://www.lemonde.fr/afrique/Article/2018/03/18/les-marocaines-attendent-toujours-la-reforme-de-l-avortement-voulue-par-mohammed-vi_5272836_3212.html; A. E. H., "Réforme du code pénal: Un deuxième texte en perspective," *Médias 24* (September 15, 2018). Available at https://www.medias24.com/MAROC/DROIT/185796-Reforme-du-code-penal-Un-deuxieme-texte-en-perspective.html.

43. Kingdom of Morocco House of Representatives, *Bill on the organization of medical pregnancy interruption* (Rabat: House of Representatives, 2018). Available at http://www.chambredesrepresentants.ma/sites/default/files/loi/085.pdf (in Arabic).

44. Association Marocaine de Lutte contre l'Avortement Clandestin, *Présentation* (2019). Available at http://amlac.org.ma/.

45. L. Hallaoui, "Avortement clandestin: Chafik Chraïbi regrette un projet de loi mort-né," *HuffPost Maroc* (January 24, 2018). Available at https://www.huffpostmaghreb.com/2018/01/24/avortement-clandestin-coup-de-gueule-chafik-chraibi_n_19070432.html.

46. A. Léfebure, "Ce que prévoit le projet de réforme du code pénal sur l'avortement," *HuffPost Maroc* (May 26, 2016). Available at https://www.huffpostmaghreb.com/2016/05/26/reforme-avortement-code-penal_n_10141896.html; R. Zaireg, "Avortement, peines alternatives, enrichissement illicite: Les nouveautés du code penal," *HuffPost Maroc* (May 26, 2016). Available at https://www.huffpostmaghreb.com/2016/05/26/code-penal-maroc-_n_10140994.html; A. Belouas, "Légalisation de l'avortement: L'Etat traîne les pieds," *Lavieéco* (July 4, 2018). Available at https://www.lavieeco.com/societe/legalisation-de-lavortement-le-tat-traine-les-pieds/.

47. C. Rainfroy, "Premier pas timide vers la libéralisation du droit à l'avortement au Maroc," *Jeune Afrique* (May 18, 2015). Available at https://www.jeuneafrique.com/232415/societe/premier-pas-timide-vers-la-lib-ralisation-du-droit-l-avortement-au-maroc/; Association Marocaine de Lutte contre l'Avortement Clandestin (see note 44).

48. Yamin and Bergallo (see note 16).

49. A. Kleinman, *Writing at the margin: Discourse between anthropology and medicine* (Berkeley: University of California Press, 1995).

50. D. L. Bowen, "Pragmatic morality: Islam and Family Planning in Morocco," in D. L. Bowen and E. Early (eds), *Everyday life in the Muslim Middle East* (Bloomington: Indiana University Press, 1993); A. Seif El Dawla, A. Abdel Hadi, and N. Abdel Wahab, "Women's wit over men's: Trade-offs and strategic accommodations in Egyptian women's reproductive lives," in R. P. Petchesky and K. Judd (eds), *Negotiating reproductive rights: Women's perspectives across countries and cultures* (London: Zed Books, 1998).

51. C. Protat, "Au Maroc, l'avortement clandestin en débat," *Libération* (June 29, 2019). Available at https://www.liberation.fr/planete/2019/06/29/au-maroc-l-avortement-clandestin-en-debat_1736880; Association Marocaine de Lutte contre l'Avortement Clandestin (see note 44).

52. Interviewees' names have been changed to protect their privacy.

53. S. Achour, H. Saadi, A. Turcant, et al., "Intoxication au

Peganumharmala L. et grossesse: Deux observations marocaines," *Médecine et Santé Tropicales* 22/1 (2012), pp. 84–86; L. Lamiar, S. Boukhorb, S. Hmimou, et al., "Profil épidémiologique des avortements provoqués au Maroc (1992/2014)" *European Scientific Journal* 14/15 (2018), pp. 406–413.

54. L. Boltanski, *La condition fœtale: Une sociologie de l'engendrement et de l'avortement* (Paris: Gallimard, 2004).

55. See C. L. Delaney, *The seed and the soil: Gender and cosmology in a Turkish village society* (Berkeley: University of California Press, 1991); N. Scheper-Hughes, *Death without weeping: The violence of everyday life in Brazil* (Berkeley: University of California Press, 1992); A. Gürsoy, "Abortion in Turkey: A matter of state, family or individual decision," *Social Science and Medicine* 42/4 (1996), pp. 531–542; A. I. Molina, "Ethnomedicine and a world-view: A comparative analysis of the incorporation and rejection of contraceptive methods among Argentine women," *Anthropology and Medicine* 4/2 (1997), pp. 145–158.

56. Scheper-Hughes (see note 55).

57. See M. Cheikh, "Échanges sexuels monétarisés, femmes et féminités au Maroc: Une autonomie ambivalente," *Autrepart* 49/1 (2009), pp. 173–188.

58. N. Guessous, "L'avortement au Maroc: La politique de 'Laissez-les mourir,'" *L'Economiste* (February 17, 2015). Available at http://www.leconomiste.com/article/966894-l-avortement-au-maroc-la-politique-de-laissez-les-mourir-par-le-pr-nouzha-guessous.

59. Ibid.

60. Morgan and Roberts (see note 1).

61. "Moroccan journalist Hajar Raissouni jailed on abortion charges," *BBC News* (October 1, 2019), Available at https://www.bbc.com/news/world-africa-49887553.

62. Mishtal (2019, see note 2).

63. S. Slyomovics, *The performance of human rights in Morocco* (Philadelphia: University of Pennsylvania Press, 2005); K. Zvan Elliot, *Modernizing patriarchy: The politics of women's rights in Morocco* (Austin: University of Texas Press, 2015).

64. El Kotni and Singer (see note 2).

The Unique Landscape of Abortion Law and Access in the Occupied Palestinian Territories

SARRAH SHAHAWY

Abstract

Abortion remains a highly debated topic in women's health in the Middle East and specifically in the occupied Palestinian territories (OPT), where it is illegal in most cases. Abortion access is challenging and complex due to laws, hospital policies, and the fragmented nature of the OPT and its health care system. This paper explores several barriers to accessing safe abortion care in the OPT, many of which are unique to living under occupation and at the interface of multiple legal systems. Legal restrictions on the provision of abortion services and the negative impact of the occupation on freedom of travel create a complex landscape in which Palestinian women are forced to navigate multiple legal and medical systems when seeking abortion services.

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Introduction

Much of the limited data on abortion in Muslim-majority countries excludes the occupied Palestinian territories (OPT), which include the West Bank, East Jerusalem, and the Gaza Strip. The OPT is often excluded in this data because the West Bank and Gaza Strip are not currently considered sovereign and there are significant data limitations in assessing the Palestinian population living under occupation.[1] Palestinian women are subject to geopolitical challenges distinct from women in other Muslim-majority countries due to the political situation in the OPT. As a result of the ongoing military occupation that began in 1967, the movement of Palestinians within the occupied territories is constantly restricted.[2] This geopolitical context poses unique challenges to health care delivery and access in general, including reproductive health services.[3] The OPT has a politically imposed fragmented landscape of health care providers, and hospitals are a mix of governmental, private, and nonprofit.[4] The obstacles to a sustainable, cohesive health care system contribute to poor overall health in the OPT, especially for women.[5] Although family planning services have long been available through facilities run by the United Nations Relief and Works Agency, the government, and nongovernmental organizations, unintended pregnancy is common.[6] A 2007 study conducted by Ayesha AlRifai for the Palestinian Family Planning and Protection Association (PFPPA) found that 40% of 333 women surveyed in West Bank refugee camps had undergone an abortion, although the study also stated that some of those women said their abortions were spontaneous and involuntary.[7] Thus, the delivery of reproductive health services is important in this population. Certain services, such as access to maternity facilities by women in labor, have been affected by the mobility restrictions imposed by the occupation, leading to decreased access to post-partum and gynecologic care and an increasing number of home deliveries and deliveries at military checkpoints.[8] There is also a shortage of obstetricians and gynecologists in the West Bank and Gaza, with these physicians being poorly distributed and concentrated in the private sector, compromising the quality of care in government institutions.[9] One qualitative study conducted in 2002 by Marleen Bosmans and colleagues found that access to sexual and reproductive health services had become significantly restricted for both refugees and non-refugees in the OPT.[10] They also found that the worsening political situation and humanitarian crisis had a negative impact on Palestinian women's health and rights by lowering the priority and funding of many sexual and reproductive health policies and programs. This is important to consider, especially in light of the fact that Palestine has ratified the Convention on the Elimination of All Forms of Discrimination against Women.[11]

Palestinian women are vulnerable to the realities of occupation, as well as historically patriarchal social and legal structures. In this paper, I examine multiple barriers to accessing safe abortion care in the OPT, many of which are unique to living under occupation and at the interface of multiple legal systems. The legal restrictions on the provision of abortion services and the negative impact of the occupation on freedom of travel creates a complex landscape in which Palestinian women must navigate multiple legal and medical systems when seeking these services. I show how these barriers are interrelated in the context of occupation and contribute to a uniquely challenging environment for obtaining safe abortions. By reviewing the limited literature on this topic and interpreting a series of cross-sectional qualitative interviews with Palestinian women, I aim to illustrate the lived way in which Palestinian women perceive how these barriers affect abortion access in the OPT.

Abortion law in the OPT

It is in the unique and complex geopolitical context of the occupation that abortion for Palestinian women must be considered. Like other countries in the Middle East, the social context, legal mechanisms, religious interpretations, and cultural factors within the OPT shape much of the conversation around induced abortion. In the OPT, abortion is criminalized under articles 321–325 of

the Jordanian Penal Code of 1960, which is derived from colonial French and Ottoman laws.[12] According to this law, penalties apply to the woman seeking the abortion and all individuals and health care professionals who assist her in terminating the pregnancy.[13] Article 8 of Palestinian Public Health Law No. 20, which was passed in 2004, states that in the West Bank and Gaza, abortion is prohibited by any means unless necessary to save the pregnant woman's life, as proven by the testimony of two specialist physicians.[14] Written approval from the pregnant woman and her husband or guardian must also be provided, and these records are kept for a minimum of 10 years. The law reflects and reinforces the sociopolitical opinion in which induced abortion should be restricted to situations in which the pregnant woman's life is in danger, which is indeed the only situation in which an abortion can currently be legally obtained in the West Bank and Gaza.[15]

Our qualitative study: Voices of Palestinian women

In 2014, my colleague Megan Diamond and I conducted a qualitative study consisting of individual interviews with 60 Palestinian women on their perceptions of the religious implications, social consequences, and accessibility of induced abortion in the OPT.[16] The recruitment and interviews took place over four weeks in December 2014 at Al-Makassed Islamic Charitable Hospital in East Jerusalem, which is uniquely situated in that it is the premier tertiary care hospital serving Palestinians living throughout the OPT in Jerusalem, the West Bank, and Gaza, allowing for a more diverse sample. We used convenience sampling to recruit participants. Inclusion criteria included non-pregnant Palestinian women over the age of 18 living in Jerusalem, the West Bank, or Gaza. Eligible participants included patients, female companions of patients, and hospital staff. The 60 women interviewed ranged in age from 18 to 70 years. The majority of participants were Muslim, married, and urban dwellers; had a high school education or less; and had at least three children. I conducted the interviews in Arabic, and both of us carried out thematic analysis of the interviews. Our study was approved by the Harvard Medical School Institutional Review Board (approval no. IRB14-4006) and the institutional review board at Al-Quds University Medical School in Palestine. Some of the data and findings from our study were published in *Culture, Health and Sexuality* in 2017.

Limited access to abortion in the OPT

Our study found that the unique legal and medical context of the OPT affected Palestinian women's access to abortion services.[17] Access to induced abortion was generally identified as difficult and complex due to laws, hospital policies, and the fragmented nature of the OPT and its health care system. When asked about the law, women were unequivocal in their answers. As one lawyer from Gaza explained in an interview, "Abortion is illegal in all cases, even in extramarital pregnancy. It is only allowed for health reasons for the mother or for fetal anomalies. The law doesn't allow for anything else, even for unmarried women or rape. They don't do it." Thus, difficulty in access is often contingent on the reason a woman is seeking an abortion. When asked whether abortion was easy to access and whether it was legal, one woman explained:

> I know that no doctor will allow me to abort without a reason—it's not easily found here with us, unless it's in a private way or through someone important you know. But still it's not common. … Everything is in secret. If it's a medical issue for the woman, then it's fine. But not for other reasons.

While women were firm in their general understanding of the abortion law, they called into question its application given the complexity of law while under occupation. As one woman exclaimed, "There is no nation. There is no law. Who is going to judge or punish? They won't get involved unless there's a problem like rape. If we had a nation and a government, then maybe there would be a law." Thus, the paralyzing legal structure in the OPT and the daunting question of statehood and sovereignty

not only prevent a true understanding of the scope of the law but also limit reforms to existing laws. Reflecting this discordance, one woman living in the West Bank said, "There is no legal punishment [for the woman]. There is no law in the country. But they'll punish the hospital or the doctor." However, while it may not be universally applied in this way, the 1960 Penal Code applies penalties both to the woman seeking an illegal abortion and to the health care personnel providing her with one. Therefore, the OPT's abortion law understandably affects hospital policies and serves as a significant barrier to abortion access among Palestinian women.

Reflective of the legal context, Palestinian hospital policies are equally restrictive with regard to abortion. One of the physicians we interviewed confirmed this:

> We've had a lot of cases who come [to Al-Makassed Hospital to abort] for nonmedical reasons and unwanted pregnancies, or unplanned. And we tell them we don't do them and refer them somewhere else. [Interviewer: Do you tell them where they can go?] No no, we just tell them to go elsewhere.

Thus, laws implicating and penalizing health care providers have contributed not only to a dearth of abortion services but also to a lack of referral services. Most women agreed that in Palestinian hospitals, particularly governmental ones, abortions were done only when the pregnant woman's life was in danger or, less commonly, if the fetus had severe anomalies. Even in these circumstances, additional barriers often arose: "Even if one doctor decides that she should abort, she has to consult a committee of doctors and obtain a letter from the religious court." Furthermore, all interviewed women unanimously confirmed that according to the policies of Palestinian hospitals, they would need their husbands' permission to abort. As one woman said, "For us here, no wives do things without their husbands' permission." As another woman noted, abortion was hard to access not only because of the legal situation in the OPT but also because a woman "can't go to the doctor other than with her husband's order." This legal requirement of physician testimony and subsequent guardian approval introduces a contrived barrier to access, placing women in a position that limits their ability to make decisions about their reproductive health.

Other studies in the OPT have also found similar barriers to abortion access, including the need to obtain the authorization of several doctors, cumbersome requirements for rape and health indications, and the need for spousal consent.[18] One study, based on the results of a 2007–2008 national survey, analyzed the attitudes of Palestinian nursing and midwifery students in the West Bank and Gaza toward abortion and contraception-related policies.[19] Its findings suggested the need to incorporate instruction on laws and policies related to sexual and reproductive health into the curricula of pertinent educational programs. Most recently, the study carried out by AlRifai for the PFPPA used quantitative and qualitative methods to assess safe and unsafe abortions (both spontaneous and induced) among Palestinian women in the Hebron Governorate in the West Bank.[20] The qualitative part of the study involved focus group interviews with health and social work professionals and found that abortion is not an accepted or encouraged practice, even among Palestinian health care providers. Given Palestinian law, hospital requirements, and negative public attitudes toward abortion, Palestinian women's access to abortion services is severely limited.

Where are Palestinian women obtaining abortions?

Although abortion is illegal, several Palestinian organizations are aiding women in obtaining safer abortions. In 2014, the PFPPA, a Jerusalem-based nonprofit organization, served more than 70,000 women, including more than 10,000 in need of abortion-related services.[21] Because abortion is illegal and highly restricted in the OPT, Palestinian women seeking an abortion are forced to turn to Israeli hospitals, to expensive private Palestinian clinics, or to self-induced termination. One Palestinian hospital staff member who was interviewed as a part of our study said, "We know there are doctors who do it in their private clinics, even if

they work [in the hospital]. I work in the hospital so maybe that's why I know but there are many who don't know I suspect. The clinics are not publicized for their abortions." Many women interviewees said that abortion could be obtained in secret through private physicians in Jerusalem and the West Bank, though this would cost a significant amount of money. As one woman explained, "A private place, ****** [a Palestinian hospital in a Jerusalem suburb], can abort for any reason with money compensation, 3,500 shekels. The doctor doesn't care if the baby is small or big." A few women made reference to women they knew who had aborted through a private physician. Most often, these physicians willing to perform illegal abortions were discovered through word of mouth.

The clinics that provide abortions seem to all be outpatient clinics, therefore limiting post-abortion care options for women who experience complications or who have self-induced their abortions. One Palestinian patient described the abortion she had through a private doctor:

> They told me about a doctor who does it special but he made me pay him a lot. A Palestinian doctor here in Jerusalem, friends told me about him—at first he tells you no, then when he sees you need it, he does it and he had aborted for them so he agrees to abort and told me it's my responsibility. It was at a private clinic. He told me the shot kills the baby and then he will give me pills for everything to come down. I didn't go to a hospital after, I stayed at home.

While neither hospital policies nor the law prevent hospitals or physicians from providing post-abortion care, some women may understandably avoid seeking such care out of fear. Some women we interviewed described the situations in which post-abortion care is sought. One woman described the process of a medical termination through a physician prescription: "[The woman] takes Cytotec from the pharmacy and performs the abortion at home and she comes to the hospital bleeding. So to save her life they do an E&C [evacuation and curettage]. It requires a prescription and they get a prescription with money from the doctor."

Other women told stories of themselves or friends trying to induce their own abortions at home, with some believing that they had successfully caused their own abortion. One woman said, "I know some who aborted at home: jumped, carried heavy things, or let her kids jump on her. And then she aborted and went to the hospital for cleaning." One woman described her own attempt:

> Every day for 4 months of my pregnancy I would jump for about half an hour. It would hurt. On the stairs, off my bed to the floor back to the bed. I wasn't merciful to myself at all. It would hurt. I lost hope that it would abort, but then at 4 months it aborted at home. I got blood coming down. And at that point, I was sad. As if I hadn't tried for this. So then I came here to the hospital so they put a pill for pain and they did a cleaning.

Restricted access to abortion can thus lead both to poor post-abortion care and to increased morbidity and mortality among women who take abortion into their own hands. A 2014 documentary, *Unsafe Abortions in Palestine*, paints a grim narrative of the medical and social factors limiting access to safe abortion services in much of the region, which results in Palestinian women pursuing unsafe abortion methods.[22] This film received support and publicity from local and international organizations such as the International Planned Parenthood Federation, Juzoor (a Palestinian NGO), and the PFPPA. As one woman we interviewed said, "She might die if abortion is not done in a legal way." Another woman explained, "Abortion can be dangerous to the mom's health. If she has an abortion in a place that's not reliable or safe, she could have negative effects later, she could even die after abortion."

These women's voices reinforce the well-established evidence that shows an association between unsafe abortion and restrictive abortion laws.[23] The median rate of unsafe abortions is 23 per 1,000 abortions in the 82 countries with the most restrictive laws, compared with 2 per 1,000 in countries that allow abortions.[24] Abortion-related deaths are more frequent in countries with more restrictive abortion laws (34 deaths per 100,000 childbirths) than in countries with less restrictive laws (1 or fewer per 100,000 childbirths).[25] Worldwide, approximately 42 million women with unintended

pregnancies choose abortion yearly, and nearly half of these procedures are unsafe.[26] Five million of these women will suffer long-term health complications, and about 68,000 die of unsafe abortion annually, making it one of the leading causes of maternal mortality.[27] Nonetheless, less restrictive abortion laws do not guarantee safe abortions for those in need, as access to health care is also required. Both liberalizing abortion law and improving abortion access face social, religious, and political obstacles.[28]

The effect of the Israeli occupation on abortion access

The obstacles to safe abortion provision and care are compounded by the realities of living under occupation. Due to the Israeli military occupation that began in 1967, Palestinians have been divided into different territories, namely East Jerusalem, the West Bank, and Gaza. The West Bank and Gaza are under distinct Palestinian rule but largely remain under Israeli military and civil control. East Jerusalem is a highly contested territory, and Palestinians living there have a "permanent residency" status, which confers fewer rights than citizenship.[29] Palestinians in the OPT can carry one of three types of IDs, each of which defines where they are allowed to freely travel within the region. The Jerusalem ID allows holders to reside in Jerusalem and enter the West Bank; the West Bank ID prevents those living in the West Bank from entering Jerusalem without applying for special permission; and the Gaza ID prevents residents from leaving Gaza. Beyond ID status, movement is largely restricted within and from the West Bank by a complex series of bureaucratic and physical obstacles, including the need for special permits to enter Jerusalem, military checkpoints, roads forbidden to Palestinians, and an eight-meter-high, 700-kilometer-long concrete separation wall that separates the West Bank from Jerusalem and Israel.[30]

Given the geographically and politically fragmented nature of the OPT imposed by the occupation, abortion laws and access differ depending on whether a Palestinian woman lives in East Jerusalem, the West Bank, or Gaza. When we asked Palestinian women living in Jerusalem about the accessibility of abortion services, one woman responded, "Access is easier here in Jerusalem and the laws in Jerusalem are light because anyone has the right no matter what. Even without a religious indication." Another woman responded, "It's easy if she has an Israeli ID because she can just go to an Israeli hospital. I don't know what they do in the West Bank."

While residents of Jerusalem have access to Israeli hospitals and residents of Jerusalem and the West Bank have access to private clinics if they can find and afford them, women interviewees felt that there is virtually no access to abortion services in Gaza. As one woman from Gaza said, "No, it is not allowed in any case in Gaza. For any reason. The doctors don't allow it in any case. [*Interviewer:* Even for medical reasons or fetal anomalies?] Yes, even so." Another woman explained, "It is pretty much impossible in Gaza. … In Gaza, there are no private clinics and they can't leave." When asked why there were no private clinics in Gaza, another woman responded, "Doctors in Gaza refuse to completely, based on what I know and my relation with the community, it's a small area and everyone knows everyone."

Women in Jerusalem seem to have the most access to abortion due to the availability of both Israeli hospitals and private clinics, while women in Gaza seem to have the least due to the absence of private clinics and the general restrictions on leaving Gaza. The majority of Palestinian women do not have access to Israeli hospitals due to checkpoints, the separation wall, and the need for special permits to enter Jerusalem. One of the only alternatives is therefore to pay a private physician to perform an illegal abortion at a private clinic for a significant fee, making this option less accessible to women of lower socioeconomic status. This is consistent with literature on clandestine abortions in the Middle East and North Africa, which notes that such abortions are provided largely by gynecologists and other physicians, with the quality of service depending on the patient's ability to pay, access to pain relief, and the use of modern or tra-

ditional abortion methods.[31] Unlike other studies in Palestine and the Arab world, the women we interviewed did not frequently mention the option of a midwife or nurse performing an abortion.[32] The few women interviewees from Gaza had special travel permits that are extremely difficult to obtain.[33] These women indicated that there were really no options for safe abortion in Gaza because hospital policies are particularly restrictive and there are no known private physicians willing to perform abortions. The permits that allowed these women to leave Gaza for medical treatment would not be sought by Gazan hospitals on behalf of women seeking abortion, making it virtually impossible to obtain a safe abortion as a Gazan woman.

Abortion through Israel: A unique quandary

Although abortion is illegal under Palestinian law unless there is a risk to the mother's life, Palestinian women are in a unique situation compared to other women in the MENA region in that they live only a few miles from a country where abortion is legal, easily accessible, and even government funded for its own citizens.[34] Israel, despite its religious, right-wing government, is among the world's most liberal countries when it comes to abortion. In 2014, the Israeli Cabinet updated a 1977 law to allow abortion if approved by a termination committee.[35] It is reported that these committees, composed of two doctors and a social worker, approve 98% of abortion requests, making abortion widely available to people living in Israel.[36] East Jerusalem, where our study was conducted, provides a unique legal and medical setting in which to evaluate abortion access for Palestinian women due to the presence of Israeli law and Palestinian principles. Interestingly, Palestinian hospitals in East Jerusalem operate in a dual fashion, generally applying Palestinian principles and policies but conforming to Israeli medical law for legal and malpractice purposes. The result of this is a complex system in which law and practice diverge. For example, physicians in Palestinian hospitals in Jerusalem are legally bound to recommend abortion during options counseling for patients diagnosed with fetal anomalies, even though the hospital itself will not provide terminations for these cases.[37]

When asked how a Palestinian woman might access an abortion if refused at a Palestinian hospital, many women answered that they could obtain one at an Israeli hospital, to which only Palestinian women living in Jerusalem or who have permits to enter Jerusalem from the West Bank have access. As one woman said:

> In Jerusalem, people have access to Israeli hospitals, even for an undesired pregnancy. … They don't have limits to 120 days like we do. Anytime she wants a termination, inshallah [God willing] even the day before she's due, they'll do it for her. ****** [An Israeli hospital] and other hospitals are private anyway and they have a committee but it's easy for a lot of things: unwanted pregnancies, illegal pregnancies, rape. They'll do it for anyone. So anyone who intends to get an abortion and can't get one here [at Al-Makassed] can go to them.

One woman said, "My sister's sister-in-law was pregnant with a baby with Down syndrome and she came here [to Al-Makassed Hospital] and they wouldn't abort so she went to ****** [an Israeli hospital] and got an abortion." As permanent residents, Palestinian women who live in East Jerusalem but are not citizens of Israel are still part of the Israeli health care and insurance system, and thus theoretically have access to abortion.[38] Palestinian women who do not live in East Jerusalem but have access to Jerusalem through special permits can also potentially access abortion, although they would have to pay a significant amount of money out of pocket given that they are not part of the Israeli health care system. As one woman explained, "It's expensive for her to come to do it [an abortion] at an Israeli hospital. But they won't do it for her at a Palestinian hospital in Jerusalem. For Israelis, they'll do it for them for free because they have insurance. But Palestinian women often don't."

While Israeli clinics and hospitals provide a unique option for a limited group of Palestinian women to obtain abortion services, the barriers to accessing abortions through the Israeli system are

not only geographic and financial but psychological and political. One interviewee living in Jerusalem expressed her strong feelings about abortion access at the intersection of multiple legal systems:

> We consider ourselves an occupied country. Israeli law is stronger than Palestinian law in Jerusalem. The West Bank has different laws. Israel is of course concerned with women's rights more. They don't have a religious view on it anyway. If anything, they let her abort more. So in the environment that I live in, I don't let Israeli law decide my rights or that I have to abort. This is my decision and my husband and my home and family's. I run by Palestinian laws. Israeli law definitely allows abortion more. But Palestinian law does not and that is what I follow.

In this way, Palestinian women might feel loyalty to their own laws and customs when it comes to reproductive health rights, even if they are more restrictive, in sociopolitical solidarity and moral resistance against the occupier. The women we interviewed made direct reference to this sense of loyalty many times, indicating that procreating directly defied the occupying force.[39] As one woman explained, "To have a baby here is a form of resistance and annoyance to our occupier. … I don't support a woman who jumps and jumps to abort the baby. Why should the Palestinian woman not have children? She should have! In order to challenge the occupier." This glorification of motherhood and procreation has a well-established history in the OPT, developing in response to Zionist political agendas since 1948 to ensure that the Israeli population in Israel far outnumbers the Arab one.[40] One of the main characteristics of the occupation has been the containment of the Palestinian population within restricted areas and the systematic movement of Israeli settlers onto Palestinian land in East Jerusalem and the West Bank.[41] As a result, population growth and control have become crucial instruments for both Israelis and Palestinians, each attempting to outnumber the other to gain control over land.[42] The Palestinian Liberation Organization and the Palestinian Authority supported this pro-natalist policy among Palestinians as a form of resistance to occupation.[43] In this way, motherhood acquires a political status among Palestinians that may be empowering but not necessarily challenging to traditional gender roles or to the standing social order.[44]

As Rhoda Kanaaneh points out in her book *Birthing the Nation: Strategies of Palestinian Women in Israel*, one of the effects of occupation has been the politicization of reproduction, procreation, fertility, and most of all, the source of these, the Palestinian woman.[45] Women have come to be considered the markers of national boundaries, with the duty to produce the babies that the nation requires.[46] This, in turn, informs the ways in which Palestinian women make and judge reproductive decisions, evident in the way some of the Palestinian women we interviewed resisted abortion on these nationalistic grounds.[47] This politicization of reproduction is not unique to Israel and Palestine, as the idea of "power in numbers" has been influential in many postcolonial nations and for dispossessed minorities striving to assert their legitimacy.[48]

Given the distrust of the Israeli occupation, many interviewees expressed doubt about the intentions of the Israeli physicians who performed abortions for Palestinian women.[49] As Kanaaneh points out, one of the major effects of both Israelis and Palestinians politicizing reproduction has been the development of distrust, especially on the part of Palestinians, of family planning initiatives and medical care.[50] Kanaaneh reports in her research that Israeli motives for encouraging contraception and abortion among Palestinians are considered suspect enough that many Palestinian women lie to the doctors and nurses from whom they seek care.[51] There has been significant literature about Zionist political movements and initiatives that view Palestinian fertility as a threat, which some argue has influenced how contraception and abortion services are provided to Palestinians in particular. This has led to distrust even of Palestinian family planning initiatives, such as those of the United Nations Relief and Works Agency, the PFPPA, and the Palestinian Authority.[52]

This distrust and doubt was reflected in our interviews with Palestinian women. As one woman pondered, "Maybe Israeli hospitals will do it

[abortion] to stop Palestinian women from procreating." Another woman said, "I don't believe in Israeli medicine, they'll just tell Palestinians that they have fetal anomalies so that they abort." One woman related such an incident: "I knew someone, whom they told at the Israeli hospital to abort for Down's syndrome. She didn't allow it and the baby was born normal. Maybe this is racism, they want to get rid of us." Although this sentiment was relatively common, a few women disagreed. One said:

> The goal of medicine in Israel, yes, they are enemies, but in a medical sense, they're like Arabs exactly. I've never seen harm on the part of Israeli medicine. I think it's excellent. Arab medicine is also good. I don't think Israelis harm us medically, or people say they tell a Palestinian woman to abort in order to take advantage. This has not happened. I haven't heard it. I've seen a lot in this life and this community, I've never heard an Israeli doctor tell a Palestinian woman to abort in order to get revenge, I've never heard, this has not happened at all. Quite the opposite, if you ask an Arab woman here with a Jerusalem ID, they prefer Israeli hospitals like ******, because insurance covers us in Israeli hospitals. … From what I've seen the Israeli hospitals are very good.

Whether or not women agreed with the practice of seeking care at Israeli hospitals, they recognized that Israel presents an option for legal abortion for some Palestinian women, a unique situation in the OPT specifically and the MENA region in general.

Conclusion and future directions

Palestinian women face multiple barriers to accessing safe abortion in the OPT, many of which are unique to living under occupation and at the interface of multiple legal systems. The worsening political situation and humanitarian crisis has had a negative impact on Palestinian women's health by lowering the priority and funding of many sexual and reproductive health policies and programs.[53] Limitations to abortion access by Palestinian women include legal restrictions, hospital policy restrictions, prohibitive prices at private clinics, fear of stigma induced by the occupation, and travel restrictions related to place of residence. Because abortion is illegal under Palestinian law and highly restricted in the OPT, Palestinian women are forced to turn to Israeli hospitals, to expensive private Palestinian clinics, or to self-induced termination when seeking an abortion. While Israeli clinics and hospitals provide a unique option for a limited group of Palestinian women, this reality is fraught with ethical and political implications that are keenly felt by Palestinians and complicate the abortion landscape. Thus, the barriers to accessing abortion under occupation are not only geographic and financial but also psychological and political. A deep understanding of the interplay between the political and historical context of occupation and its effects on reproductive rights and choice is crucial in the war-torn context of Palestine for those working to provide better support and access for Palestinian women navigating the intimately challenging circumstances of abortion.

References

1. G. K. Shapiro, "Abortion law in Muslim-majority countries: An overview of the Islamic discourse with policy implications," *Health Policy and Planning* 29 (2014), pp. 483–494

2. R. Horton, "The occupied Palestinian territory: Peace, justice, and health," *Lancet* 373 (2009), pp. 784–788; A. Becker, K. Al Ju'beh, and G. Watt, "Keys to health: Justice, sovereignty, and self-determination," *Lancet* 373 (2009), pp. 985–987.

3. Horton (see note 2); R. Giacaman, R. Khatib, L. Shabaneh, et al., "Health status and health services in the occupied Palestinian territory," *Lancet* 373 (2009), pp. 837–849.

4. B. Kerr Winter, R. M. Salamma, and K. A. Qabaja, "Medical education in Palestine," *Medical Teacher* 37/2 (2015), pp. 125–130.

5. Giacaman et al. (see note 3).

6. M. St-Jean, *Assessing nursing and midwifery students' attitudes toward abortion and contraception: Results of a national survey in the occupied Palestinian territories* (2015, University of Ottawa).

7. A. AlRifai, *Assessment of safe and unsafe abortion among Palestinian women in Hebron Governorate in southern West Bank, Palestine* (Palestinian Family Planning and Protection Association and International Planned Parenthood Federation, 2015).

8. H. Abdul Rahim, L. Wick, S. Halileh, et al., "Maternal and child health in the occupied Palestinian territory," *Lancet* 373 (2009), pp. 967–977; M. Bosmans, D. Nasser, U.

Khammash, et al., "Palestinian women's sexual and reproductive health rights in a longstanding humanitarian crisis," *Reproductive Health Matters* 16 (2008), pp. 103–111.

9. Abdul Rahim et al. (see note 8); Palestinian National Authority, Ministry of Health, Health Planning Unit, *National strategic health plan: Medium term development plan 2008–10* (2008).

10. Bosmans et al. (see note 8).

11. Convention on the Elimination of All Forms of Discrimination against Women, G.A. Res. 34/180 (1979).

12. *Jordanian Penal Code No. 16 of 1960*. Available at https://jordan-lawyer.com/2017/04/05/jordan-criminal-law.

13. Ibid.

14. *Public Health Law. No. 20* (2005). Available at http://www.hdip.org/public%20health%20law%20English.pdf.

15. L. Hessini, "Islam and abortion: The diversity of discourses and practices," *IDS Bulletin* 39 (2008), pp. 18–27.

16. S. Shahawy and M. B. Diamond, "Perspectives on induced abortion among Palestinian women: Religion, culture and access in the occupied Palestinian territories," *Culture Health and Sexuality* 20/3 (2017), pp. 289–305.

17. Ibid.

18. Hessini (see note 15).

19. St-Jean (see note 6).

20. AlRifai (see note 7).

21. Y. Schwartz, "Palestine's abortion problem," *Foreign Policy* (December 4, 2015). Available at https://foreignpolicy.com/2015/12/04/palestines-abortion-problem.

22. International Planned Parenthood Federation, *Unsafe abortion in Palestine*. Available at http://www.ippf.org/resource/Unsafe-abortion-Palestine.

23. L. B. Haddad and N. M. Nour, "Unsafe abortion: Unnecessary maternal mortality," *Reviews in Obstetrics and Gynecology* 2/2 (2009), pp. 122–126.

24. D. A. Grimes, J. Benson, S. Singh, et al., "Unsafe abortion: The preventable pandemic," *Lancet* 368 (2006), pp. 1908–1919.

25. World Health Organization, *Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008*, 6th ed. (Geneva: World Health Organization, 2011).

26. Haddad and Nour (see note 23).

27. Grimes et al. (see note 24).

28. Haddad and Nour (see note 23).

29. B'Tselem, *East Jerusalem*. Available at https://www.btselem.org/jerusalem.

30. Winter et al. (see note 4).

31. Hessini (see note 15); S. D. Lane, J. M. Jok, and M. T. El-Mouelhy, "Buying safety: The economics of reproductive risk and abortion in Egypt," *Social Science and Medicine* 47/8 (1998), pp. 1089–1099.

32. AlRifai (see note 7); Shahawy and Diamond (see note 16).

33. Shahawy and Diamond (see note 16).

34. Schwartz (see note 21).

35. *Penal Law, 5737-1977*, ch. 10, art. 2; International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI) (1966), art. 12; D. Kamin, "Israel's abortion law now among world's most liberal," *Times of Israel* (January 6, 2014).

36. Kamin (see note 35).

37. Shahawy and Diamond (see note 16).

38. Schwartz (see note 21).

39. Shahawy and Diamond (see note 16).

40. R. A. Kanaaneh, *Birthing the nation: Strategies of Palestinian women in Israel* (Berkeley: University of California Press, 2002).

41. Bosmans et al. (see note 8).

42. J. Abu-Lughod, "The demographic war for Palestine," *Link* 19 (1986).

43. Kanaaneh (see note 40).

44. J. Peteet, "Icons and militants: Mothering in the danger zone," *Signs* 23/1 (1997), pp. 103–129.

45. Kanaaneh (see note 40).

46. Haddad and Nour (see note 23); Hessini (see note 15).

47. Kanaaneh (see note 40); Shahawy and Diamond (see note 16).

48. Kanaaneh (see note 40); E. T. Zureik, "Constructing Palestine through surveillance practices," *British Journal of Middle Eastern Studies* 28/2 (1999), pp. 205–227.

49. Shahawy and Diamond (see note 16).

50. Kanaaneh (see note 40).

51. Ibid.

52. Ibid.

53. Bosmans et al. (see note 8).

Neoliberal Health Restructuring, Neoconservatism and the Limits of Law: Erosion of Reproductive Rights in Turkey

AYSE DAYI

Abstract

Through focusing on the neoliberal "Health Transformation Programme" launched in 2003 in Turkey, I show how reproductive law can be modified by neoliberal mechanisms that are implemented with neoconservative policies and pressures. The paper builds on original data collected in 2014 and 2015 through focus groups and interviews with health practitioners in family health centers and women receiving reproductive care in Izmir, Diyarbakir, Van, and Gaziantep. The data analysis informed by writings on the debt economy by Maurizio Lazzarato and Bifo Berardi and transnational feminist theory demonstrate that neoliberal mechanisms of "dismantling the public" interact with pronatalist policies and pressures to erode women's reproductive rights in Turkey. This has resulted in (1) indebtedness of women through out-of-pocket payments for contraception and abortion, (2) indebtedness of providers through performance measures, (3) reduction in the quality of reproductive care, and (4) reduction in access to reproductive care itself (contraception, counseling, and abortion). There is a need to pay attention to neoliberal mechanisms and the legal framings of reproductive rights to fully understand the limitations of law and counter the neoliberal and conservative assaults on women's sexual and reproductive rights.

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Introduction

Turkey is one of the two countries in the MENA (Middle East and North Africa) region, along with Tunisia, that allows abortion on demand. Abortion was decriminalized in 1983 within the framework of state demographic policies rather than as a women's right. At the turn of the 21st century, neoliberal reforms, the restructuring of the public health sector, and the pronatalist and conservative ideology promoted by the Justice and Development Party (AKP) have made abortion access difficult for many women, although the law has not changed.

In this paper, focusing on the neoliberal restructuring of health care in Turkey through the Health Transformation Programme launched by AKP in 2003, I explore how the combination of neoconservative discourses and neoliberal mechanisms have modified reproductive law and curbed women's exercise of rights. I introduce the concept of debt economy and examine how it has affected the governance of sexual and reproductive health in the public sector by focusing on various devices, such as the semi-privatization of services, performance measures, the bureaucratization and quantification of care, and the transformation of health professionals' working conditions and status. Whereas most scholars who write on neoliberalism and gender in Turkey use Foucauldian approaches and highlight discourses rather than economic mechanisms, I utilize a political-economic lense. I contribute to the feminist literature on globalization and gender by offering a political-economic analysis of neoliberal health restructuring and reproductive rights.[1]

Drawing on original fieldwork in Turkey, I conclude by showing that the combination of neoliberal reforms and neoconservatism has brought about drastic reductions in contraceptive and abortion services in the public sector, with expectedly worse results for young single, poor, and rural women. The indebtedness of women through out-of-pocket payments for contraceptive and abortion care; increased workload of health care workers; exclusion of family planning counseling, contraception, and initially, voluntary abortion services from performance measures; and decrease in abortions provided in public hospitals are among the results of these policies and implementations.

History of reproductive rights in Turkey

Under the Ottoman Empire, abortion, called *iskat-ı cenin* (miscarriage of a fetus), was regulated by religious law and was allowed up to 120 days of pregnancy on demand and in cases of a threat to the pregnant woman's life. With Ottoman modernization, a rising interest in population statistics, and concern over the declining Muslim population, abortion began moving from the religious to the legal jurisdiction, marking the beginning of biopolitics.[2]

The Turkish Republic, established in 1923, adopted the 1889 Italian Criminal Code, with its initial Catholic and later eugenic influences. Initially defined under "crimes against individuals" (1926), abortion moved to "crimes against racial integrity and health" and against "general public morality and family order" in 1936.[3] During the 1930s–1950s, the country prohibited abortion, contraception, sterilization, and the provision of information on contraceptive methods, and it also explored the option of rewarding of women with six or more children with medals. These actions reflect a continuation of the Ottoman Empire's pronatalist policy, applied with nationalist and eugenic aims, this time to increase a population that had been depleted through wars. In the aftermath of the 1960 coup and the new Constitution, a range of developments—including the international shift in population policies whereby growth was viewed as a hindrance to economic development; the formation of Turkey's State Development Agency; the socialization of health care; the family planning work of public health specialists such as Nusret Fisek; and an appeal to the Ministry of Justice in 1958 by the Ministry of Health, university professors, criminal medicine experts, and the Turkish Gynecological Association to remove the ban on birth control methods—led to the passing of the Law on Population Planning in 1965. With this law, birth control and therapeutic abortions were legalized, and contraception was regulated under a "family planning" perspective, with new clinics formed to

provide free contraceptive care and counseling to women. Abortion and birth control thus moved to the medical domain, supervised by the state.

When the global abortion debate reached Turkey in the 1970s, the Turkish Medical Association, Turkish Family Planning Association, and Turkish Gynecological Association started advocating for the legalization of abortion on demand. After the introduction of multiple bills (in 1971, 1972, and 1979) to legalize abortion, and the results of public health research showing the widespread provision and use of abortion by doctors and women, and its link to maternal deaths in cases of unsafe abortions, in 1983 abortion on demand was legalized through a revision of the 1965 Law on Population Planning. The revised law states:

> *Population policy is defined as individuals having as many children as they wish to, when they want to. The state takes the necessary steps to provide education and implementation of population planning. Population planning is enabled by the methods preventing pregnancy. The termination of pregnancy and sterilization are done under the supervision of the state. Pregnancy terminations and sterilizations beyond those provided for under this law may not be performed.*

Even though the bill proposed a 12-week cut-off for abortion, objections by the Health and Social Work Commission led to it being passed with a 10-week cut-off instead, after which point abortion can be obtained only in cases of medical necessity. The law requires a husband's written consent for married women seeking an abortion, and parental consent from minors. According to regulations, in addition to obstetrician-gynecologists (ob/gyns), general practitioners who receive training can also perform abortions under the supervision of an ob/gyn.

In recent years, there has been a reignition of the abortion debate and the promotion of a pro-natalist policy by the AKP, the party in power in Turkey since 2002. Initially calling itself moderate Islamic, the AKP today can be best described as representing "an amalgam of neoliberalism with social conservatism."[4] The social policies of AKP have at their center anti-women and at times misogynist discourses, policies, and implementations that reposition women in familial roles, overturning decades of gains by feminist movements in Turkey toward the recognition of women as individuals and citizens in their own right.[5] During the March celebrations in 2008, then-prime minister Erdogan announced the government's plan to introduce financial incentives for births, which from 2009 onward quickly turned into a formulation of a "three children per family" (that is, per woman) policy. The initial sign of this shift of policy—from an antinatalist stance upheld since the 1960s to a pro-natalist one—can be seen in 2003, when the government attempted to redraft the Law on the Rights of the Disabled to restrict therapeutic abortions (done after 10 weeks), even in the cases of fetal disability.[6] Due to objections by women's organizations, medical associations, and media, the proposed article was removed from the draft. Yet Erdogan made a statement in May 2012, during the closing session of the International Parliamentarians' Conference on the Implementation of the ICPD Programme of Action in Istanbul, saying that abortion was mass murder (referencing the killing of 34 Kurdish citizens in Uludere for which his government had been critiqued). He also condemned Caesarean sections, declaring both abortion and Caesarean sections to be "secret plots designed to stall Turkey's economic growth and a conspiracy to wipe the Turkish nation from the world stage."[7]

Erdogan's remarks on abortion were met with criticism from opposition parties and his own minister of family and social policy, but more importantly with a strong reaction from the feminist movement in Turkey, which organized nationwide sit-ins and protests under the slogan "abortion is a right and a woman's decision." As a result of this activism—together with studies by Mor Cati (Purple Roof Women's Shelter), and Kadir Has University, among others, monitoring the status of abortion care in Turkey—the government's attempts to change the abortion law have been unsuccessful.[8] However, as discussed in this paper, the neoconservative discourse and pressure from state officials, applied alongside neoliberal mechanisms such as performance measures, have led to a serious decrease in abortion in Turkey.

As can be seen from this history, reproductive law in Turkey has been shaped in the context of population policies instrumentalizing women's bodies and sexuality. While the population control agenda and the restrictions on abortion it brings persist as the governing legal framework, the years 1965–2009 saw more of a family planning approach —despite population control approaches applied to poor women and minorities—which evolved (at least in reproductive policies) in 1990s to include a "women's rights" approach. This was due to Turkey's support for international documents emphasizing women's sexual and reproductive rights as human rights, including the International Conference on Population and Development (ICPD) Programme of Action, UN Sustainable Development Goals (SDGs), and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which it ratified in 1985.

Recent steps toward a pronatalist policy and attempts to change the abortion law are in contradiction with these commitments. How reproductive services and rights can be eroded while still adhering to these commitment and without any change in laws reflects a need to focus on the political economic dimension of neoliberalism, as allied with neoconservatism.

The debt economy

Lazzarato calls the latest stage of neoliberalism (starting in the late 1990s) the "debt economy."[9] In the debt economy, finance dominates every sector of the economy and society—from housing, education, and health to public services.[10] Individuals, public entities, municipalities, and entire governments are controlled through debt. The debt accumulates when colossal sums of public money are transferred into private hands through privatization and the imposition (by banks, rating agencies, and investment agencies) of interest rates and determination of "appropriate rates" of unemployment wages, pensions, public services, and public debt of governments and municipalities. Through these actions, the public sector (including the welfare state) is completely dismantled and privatized, public debt is created, and the state is turned into a regulator of services, itself bound to credit and debt mechanisms.[11] Berardi adds to this phenomenon the "mathematization of life and language," whereby neoliberal ideology submits production and social life to the most ferocious regulation, as seen in increasing uses of "efficiency," "performance measures," and the quantification of welfare and health services and of education.[12]

Neoliberal health restructuring in Turkey

The neoliberal assault on welfare systems includes health care restructuring, as seen in the emergence of a "health reform epidemic," or, in World Bank discourse, "health sector reforms."[13] These reforms were largely undertaken in the late 1980s and early 1990s in "developing" countries such as Brazil, Mexico, South Korea, and Taiwan, whose public sectors were denigrated as corrupt and inefficient and where markets were seen as a panacea to their "health care crises" and other problems.[14] In Turkey, the AKP's Health Transformation Program (launched in 2003) also outlined an agenda to "improve governance, efficiency, user and provider satisfaction, and the long-term fiscal sustainability of the health care system" and is part of this global neoliberal trend.

As in these other geographies, the Turkish health reform also originated in the late 1980s, when certain neoliberal economic and health policies were proposed (for example, the 1987 Health Services Law) and others (such as TRIPS) were applied. The reform took shape within the Ministry of Health through reports prepared by public health academics of Harvard and Johns Hopkins Universities, in consultation with World Bank advisers.[15]

The Turkish health reform shares many characteristics of the neoliberal global health reforms, such as financial reform, managerial reform, changes in service provision, decentralization, and the quantification of services over quality of care in the name of "cost reduction" and "efficiency." Changes in health care provision include the closing down of the AÇSAP (Mother-Child and Family Planning) Directory, which had specialized in

reproductive health provision in primary care, and the introduction of the "family physicians system." In this system, health centers (sağlık ocağı) and AÇSAP centers were replaced with family health centers (FHCs) and "community health centers" (toplum sağlık merkezleri) at the primary care level. Family physicians, the intended "gatekeepers" of the system, would provide preventative care and refer patients to secondary level for specialized care.[16] Unlike the previous system, the family physician system involved a form of semi-privatized care, which added to the ongoing privatization of care. Family physicians work as contract workers who contract midwives and nurses for a period of two years, and their wages are based on capitation set by the socioeconomic development of their region. Their salaries—as well as those of midwives and nurses—are subject to performance criteria and can be cut by up to 20% when they fail to reach their targets. Furthermore, FHCs, instead of serving a particular geographic area (as was previously the case), serve the population that registers under them. Physicians compete with one another to keep their patient populations and to maintain patients with less chronic problems.

A multisite feminist research-advocacy project

The data used in this paper comes from a larger multisite feminist research and advocacy project that my co-researchers and I designed to investigate the effects of neoliberal health restructuring on sexual and reproductive rights in Turkey, France, and the United States. A previous article with Eylem Karakaya includes findings from FHC health care workers in Turkey.[17] In the current paper, adding women's voices to those of providers, I focus on the relationship between neoliberal health restructuring, neoconservativism, and reproductive law and population policy. Although the focus of this special section is on abortion, I discuss contraception and abortion together, since these are intricately linked rights and practices in the lives of women. When the right to one is affected, the other inevitably suffers.

Methodology

The overall study includes data collected in 2014 and 2015 from seven cities: İstanbul, İzmir, Antalya, Van, Eskişehir, Diyarbakır, and Gaziantep. These cities reflect the geographical variations in reproductive health care access as found in the Turkish Population and Health Survey, conducted every five years.[18] Within a geographical diversity, we chose cities where we had connections to women's organizations and medical associations that would help us recruit participants. This paper includes an analysis of four of these cities: Izmir, Diyarbakir, Van, and Gaziantep. We completed 313 surveys with women (aged 18–45) in all four of these cities; 103 surveys in Diyarbakir and Antep with reproductive health personnel who worked in the public sector at the primary and secondary levels; and 14 focus groups with women (aged 18–45) and 8 focus groups and 3 individual interviews with FHC personnel in all cities except Van. Personnel came from 11 FHCs and one AÇSAP center. All interviews were transcribed verbatim and analyzed using the grounded theory approach.

The mean age in our focus groups was 35.5 for women and 36.6 for health personnel. In terms of marital status, there were more single women (53.6%) than married women in our focus groups. The health personnel who participated in surveys and focus groups were mainly female health workers (77.7% for surveys and 85.7% for focus groups), with the majority being nurses or midwives (75.7% of health workers in surveys and 81.8% of health workers in focus groups). Thus, the results from health providers reflect the viewpoints of the feminine labor force on health care restructuring. In this paper, I utilize focus groups with health providers and women receiving public and private reproductive care.

Findings and discussion

Dismantling public health care via neoliberal mechanisms and the bureaucratization of care

In Turkey, we found that the dismantling of the public sector in health care is accomplished via

mechanisms of privatization, the introduction of hidden and explicit user fees, the introduction of market concepts such as (the illusion of) "choice" of provider and "customer satisfaction," and the introduction of market mechanisms such as performance measures. In terms of sexual and reproductive health care, the closing down of the directory for AÇSAP and most of its centers—which had specialized in providing sexual and reproductive care, including contraception, abortion, and counseling and education on sexual and reproductive health—and their replacement by FHCs and community health centers (TSMs) affected women's access to contraception, family planning counseling, and abortion.[19]

Under the new system, FHCs are divided into four categories (A, B, C, and D), with only A and B types having an additional room with an ob/gyn table. Having a general practitioner trained in intrauterine device (IUD) insertion can move a center from C or D status to B status. According to a report by UNFPA Turkey on access to family planning services and contraception, this differentiation has led to inequality in access to care.[20] The FHC system had replaced the previous teamwork between physicians, nurses and nurse-midwives, to a physician-based scheme, where the physician is transformed into an "entrepreneur" who contracts personnel and pays rent and any material costs that arise. Nurses and midwives, in turn, have become contractual workers whose professional titles are now "family health worker" instead of "nurse" or "nurse-midwife," causing them to lose both professional status and the job security granted previously by their public worker status. This semi-private functioning of the centers and the transformation of the doctor-nurse relationship into an employer-employee one was not appreciated by the health workers we interviewed:

> *The community health centers had to be updated and adapted to the years 2016s and 2017s and it wasn't done. That wonderful system is gone now and in its place we have a commercial- (pause). Like the commercial agencies, but we are not that. In between. We pay the electricity, water, internet, heating, cooling, everything. Hired five personnel. If something happens to this place, we pay for it. From our own thing. We get a tax number and spend 70% of our time with this nonsense [another health worker in the room interjected "management"] work.*
>
> —Mehmet (male), age 52, physician, A-type FHC, Antep

> *There are problems both in terms of the money we receive, and status ... and it's like a boss-employee relationship. Intentionally or unintentionally. Even though they [doctors] don't pay you, we are in that position.*
>
> —Gul (female), age 35, midwife, A-type FHC, Antep

Under the new system, performance measures apply to both hospital and FHC work. Under Turkey's Healthcare Application Communiqué (Sağlık Uygulama Tebliği), which defines performance points for various health services, a performance code was initially given only to "therapeutic abortions" (beyond the 10-week legal period), leaving abortions on demand undefined and thus excluded from social security coverage. It was only in 2014 that the code was changed to "dilation and curettage services."[21] In terms of sexual and contraceptive care, in the FHCs, physicians, nurses, and nurse-midwives are subject to performance measures in areas such as the rate of referrals, child vaccinations, and prenatal and infant follow-ups and can lose up to 20% of their salary if they do not meet their targets. Nonetheless, they are not evaluated for sexual and reproductive health counseling (called "family planning counseling") or contraception supply, including IUD insertions. Such performance measures are a neoliberal market mechanism (used alongside conservative pronatalist aims) applied through bureaucratic means, since they are introduced with the aim of increasing "efficiency" by standardizing measures of accountability. To better understand the workings of performance measures and their effect on reproductive rights, I will proceed to the second arm of the dismantling of the public health care sector: the bureaucratization of care via digitalization and performance measures.

Lazzarato describes the debt economy's use of evaluation as a technique to govern the behavior

of individuals, populations, agencies, and governments. Berardi discusses in additional depth the effects of this mathematization of language, discourse, and life.[22] In our research, we observed the bureaucratization and resultant quantification of care through performance measures and increased paper and computer work, which has had direct consequences on women's rights to contraception. Despite the reform's aims to improve "efficiency," providers in our research mentioned an increased workload and lack of efficiency. Indeed, 86.4% of health providers stated that their workload had grown since the health reform. This increase was due to the performance measurement system and the newly computerized system, which did not work efficiently:

> *Ayse: Sometimes I think that they make us do too much drudgery ... for example, we print out the monthly work and transfer it from the computer into paper work, then you scan and enter it back into the computer, correct it within the EBES system, send it ... Remove the monthly work. If you already have a system, why is it this way? Why do you waste so much paper? If the system goes down, everything is affected. You can't send something for hours.*
> *Fatma: yes, this is extra work for us*
>
> —Ayse (female), age 37, midwife; Fatma, age 29, nurse, A-type FHC, Diyarbakir

The performance measures, together with the increased workload (caused by digitalization and the extra work required by performance measures), affect sexual and reproductive care by decreasing the quality of care provided and decreasing care itself that is excluded from performance measures. For example, the nurses and midwives we interviewed stated that they were unable to find time to offer sexual and reproductive counseling and that, due to a lack of training and work overload, they were not willing to insert IUDs:

> *As the workload increases, as one does polyclinic, and needs to follow the women aged 15–49 [meaning prenatal follow-ups for reproductive-age women] and checks on obesity, you can't catch up. If you do one, the other is definitely left out.*
>
> Malin (female), age 42, physician, B-type FHC, Izmir

In their research on family health center and community health center providers, Zeliha Asli Ocek et al. documented problems even with the services that are under performance criteria (for example, in identifying pregnant women and infants among individuals who did not register with the family physician) and problems with the quality of prenatal and infant care.[23] They also found, as we did, instances of fraud in prenatal follow-ups and child immunizations. The ratio of pregnant women and infants not covered by the new system, as well as problems in the quality of care, reveal that the quantification of care does not guarantee its quality or "efficiency." Indeed, the World Bank admits that "the performance-based contracting scheme in Turkey started out mostly as a 'pay for quantity' approach and does not incentivise the clinical process dimension in quality of care."[24]

In terms of the decrease in sexual and reproductive care, the decrease in IUD provisions in FHCs has been detected both by researchers and by the results of Turkey's 2013 Demographic and Health Survey, which show that the use of IUD among married women fell from 18.8% in 1993 to 16.8% in 2003, with the decrease first visible in 2008 (five years after the beginning of the health restructuring).[25] A decrease in family planning counseling has also been reported by both Ocek et al. and Ceren Topgul et al.[26] As they noted, I also found that the decrease in counseling and IUD provision are due to an increased workload, exclusion of these services from performance measures, and lack of adequate training:

> *The last time I placed an IUD was last year ... I don't find it appropriate to do it here [Interviewer: Why?] Because there are patients waiting and there is the time for that patient ... And when you don't do something regularly, you lose the pratice. So I try to refer the patient to where IUDs are placed ... Like maternal-child health centers.*
>
> —Zeynep (female), age 43, midwife, B-type FHC, Izmir

> *If it was me, I would not have an IUD placed here. For example, I went and learned the IUD placement on a model. How can I do it on a woman, something I only performed on a model? I can neither place an*

IUD nor do [pap] smears. [Interviewer: Didn't you practice before receiving the certificate?] We did not receive a certificate. A training for 20 minutes only.

—Cicek (female), age 40, nurse, A-type FHC, Diyarbakir

In addition to performance measures, digitalization, and inadequate staff training, another bureaucratic mechanism that impedes women's access to contraception are periodic problems in the supply of contraceptive methods to FHCs by the city health ministries. In all of the cities where we conducted our research, women and providers mentioned these periodic irregularities in supply. In Topgul et al.'s study, family physicians in FHCs also reported such irregularities, which they interpreted as reflecting the anti-contraception attitude of the state and a lack of coordination between the ministry, community health centers and family health centers after the reform. In our study, some health providers attributed the problems to the Ministry of Health's incorrect calculation of their needs or to not being properly informed when supplies had arrived. Moreover, Topgul et al. point out the links between changes in the financing of contraceptive methods and the lack in supplies. They state that the supply of contraception in Turkey from 1965 to 2000 was financed mainly by international funds, with USAID being the largest funder.[27] When USAID started to decrease its financial support between 1995 and 1999, the Turkish Ministry of Health had to finance the methods, which led to decreases in supply in 2000 and 2001.[28] The Ministry of Health decentralized the method acquisition. However, when this created a standardization problem, the Ministry recentralized the acquisition. The problem remains, as public bids in contraception acquisition involve long processes and include cancellations. According to UNFPA, no purchases were made by the Ministry of Health in 2012.[29]

While the reasons for these constant irregularities need to be further investigated and monitored, the result is the violation of women's right to free contraception at the primary level, which leaves women with the options of paying out of pocket (becoming indebted), changing to another contraceptive method available at the FHC, or continuing an unwanted pregnancy. As our interviewees noted:

Fatma: Last year, we had nothing for four months except for the injection.
Anonymous: Most of the time the ministry buys it but it doesn't come to us, waits there. The municipality doesn't inform us. There is a waiting. It's a two-way problem. Problem emanates 80–90% from the ministry.

Interviewer: Okay, so when there is nothing and the woman comes and asks for a method, what do you do?

Ayse: They become pregnant. Because you know the pill in the pharmacy is 18 lira. They can't buy it. They can buy as much as they can from the pharmacy, otherwise they become pregnant.

—Fatma (female), age 29, nurse; Ayse (female), age 37, midwife; anonymous (male), age 43, physician, A-type FHC, Diyarbakir

There are those who get pregnant. There was no pill for a while for example, and we saw many women who got pregnant and gave birth to their whateverth number child.

—Habibe (female), age 42, physician, B-type FHC, Izmir

Zehra: In 2008, there was a commnutity health center below us and nurses from there said that women could access condoms and pills from the centers. But a bit later, there was no emergency pill or birth control pill.
Elif: The nurse in my family health center told me that she fits IUDs, but that her physician does not know it. Told me she can fit me one but I know they don't provide condoms anymore.

—Focus group with women, Izmir

Interviewer: Is the IUD placed in FHCs here?
Havva: In some but not all.
Interviewer: How about injected contraceptives or condoms?
Havva: That might be changing according to location of the center. Some have it but some say they have problems getting these and forced the budget and have their unit buy these ... They say at meetings that they have much difficulty when the supplies are finished.

—Focus group with women, Antep

The exclusion of contraceptive care and family planning counseling from performance measures, low performance points given to abortion in hospitals, and periodic irregularities in contraceptive supplies are in line with the AKP's pronatalist policy. This ties in to the last part of our findings, which relates to how conservative discourse and pressure has led to a decrease in abortion and contraception access, thus violating women's reproductive rights.

Conservative discourse and pressure on providers

In our focus groups, we asked providers and women about abortion and birth control access in their cities since the health reform. We were surprised to learn that not only most of the women but also most of the health providers were confused about the legal status of abortion. Some thought it was banned while others were not sure whether the legal time limit had been shortened.

> *Firuze: I would not go to the public hospital. I would consult my doctor, but if I needed an abortion, I would not go to public, since I know that it's illegal.*
> *Interviewer: Do you think or know that abortion is banned in public hospitals?*
> *Nuray: The government has such a policy.*
> *Zehra: I mean that in practice it's not done, not easily. They make it harder.*
> *Firuze: I know that if the husband consents, it can be done.*
>
> —Focus group with women, Izmir

> *For example, umm the prime minister, umm telling women to give birth, I heard that he banned ... I went to the community health center three years ago, there was no birth control pill, the president banned it. [Interviewer: Did they say that?] Mmhmm. [Interviewer: At the community center?] Yes.*
>
> —Azra, focus group with women, Antep

> *I know that abortion on demand is banned.*
>
> —Irem, focus group with women, Izmir

These testimonies show that the conservative discourse that started with Erdogan's remarks in 2012 that "abortion is murder" was successful in muddying the waters and creating confusion on the legal status of abortion, as well as pressure on providers, without actually changing the law. The decrease in abortions in public hospitals throughout Turkey was documented in a recent survey of state hospitals and teaching state hospitals by Kadir Has University.[30] Our interviews showed that abortion has become more difficult in public hospitals in recent years due to service rejection and to requests by providers that the pregnant woman obtain her husband's or parents' consent:

> *if we can collect money, we send the women [we work with] to private hospitals. When there is no husband, the public ones reject them anyway. In the private, there is resistance as well. I have been doing this job [working at a women's shelter] for seven years. For the last three years, we have had serious difficulties about this [accessing abortion]. The number of kids we give [for adoption] to protection services is too many. There are many pregnant women coming to us, ending their pregnancies and returning home. They have no other way of hiding their pregnancies. Why couldn't you abort? "I had no money." But this is a public service. But if it's recorded in her social security, anyone can access it and now they inform the husbands, parents, by text message ... So, she has no other option.*
>
> —Elif, women's focus group, Izmir

> *Meryem: In public hospitals now, they don't do it [abortions] if there is no problem [medical necessity].*
> *Zeynep: I went and said I do not want this pregnancy, went to the birthing hospitals. They said go bring your husband, he signs and we do it ... And I was scared.*
>
> —Women's focus group, Diyarbakir

Health providers also feel pressured to avoid talking about and providing abortion and birth control and noted the newly brought scrutiny on the husband's signature for abortion, which previously had not not been so strictly enforced by health providers:

> *Actually, there is a change [from the community center model to the family health center model]. A change in views. How can I say this ... Abortion is legal, but there is an incentive not to provide it. You can't talk about it, talk about this different point of view. For example, the person says, "I don't want to*

> *give birth, I want to use protection," and you get the feeling that you are doing a wrong thing mentioning the methods. ... There is such a change here and it exists on abortion too. It is legal, so I still don't understand why the husband comes. And you take the husband's signature.*
>
> —Ayse (female), age 39, physician, D-type FHC, Antep

Among our study participants, single women (most of them young) stated that they found it difficult to access contraceptive and abortion care from the public sector, out of fear or due to real experiences of being judged for being sexually active. When they can, single women utilize private care. Fusun Artiran Igde et al. point to how the legal restriction of abortion provision to ob/gyns and to general practitioners who work under the supervision of ob/gyns contributes to urban-rural inequalities in access to abortion since rural areas lack ob/gyns.[31] Given the climate of conservative and patriarchal care, where some providers do not feel comfortable talking to or treating single women, these new conservative pressures, together with the existing limitations of the law itself, will disproportionately affect poor women, young single women, and rural women, who will be forced to pay out of pocket for contraceptive and abortion care, to seek unsafe abortions, or to carry unwanted pregnancies to term.

Conclusion

In this paper, drawing on the writings on the debt economy and a transnational feminist lens, I have discussed how neoliberal mechanisms, with their marketplace-oriented and bureaucratic arms, interact with conservative policies to erode women's reproductive rights in Turkey. To summarize, the neoliberal-neoconservative restructuring of health care in Turkey has resulted in (1) the indebtedness of women through out-of-pocket payments for private contraceptive and abortion care; (2) the indebtedness of physicians, nurses, and midwives to the state through salary cuts from missed performance targets (and use of fraud to avoid these misses); (3) a reduction in the quality of existing reproductive care (such as prenatal follow-ups); and (4) a reduction in access to reproductive care itself (namely contraception, sexual and reproductive counseling, and abortion).

In Turkey, women's rights to contraception and abortion did not come about as a result of demands by the feminist movement; rather, they emerged in the context of antinatalist policies combined with public health concerns regarding maternal deaths. As Elif Aksit argues, the AKP's pronatalist policy can, in one way, be seen as a continuation of the approach to women's bodies, reproduction, and sexuality in Turkey that has been in place since the late Ottoman period, whereby reproductive rights are treated in the context of population policies.[32] The difference from previous times is the extension of the state's biopolitics to the regulation of assisted reproductive technologies (such as infertility treatments and sperm donations) and the application of neoliberal market mechanisms together with conservative ideologies aimed at controlling women's sexuality.[33]

I believe that the way in which reproductive rights in a country are gained and laws formulated affects the susceptibility of the laws (and rights) to actual or de facto modifications by market and conservative mechanisms. For example, in the United States, *Roe v. Wade*, which legalized abortion in 1973, is phrased as protecting women's "right to privacy" in a decision made with the doctor and in which the state preserves its interests to intervene on behalf of the woman or the fetus. It is not surprising that immediately after abortion's legalization, the Hyde Ammendment (1977) preventing federal coverage of abortions was passed. Senator Hyde argued that this was a not a limitation, since women were *free to choose* another (private) provider for abortions. In the United States, we can also see how neoliberal mechanisms (such as increasing malpractice lawsuits against ob/gyns, changing zoning and operation room requirements for abortion clinics, and the defunding of Planned Parenthood) have been used alongside conservative measures (such as mandatory waiting periods, parental consent or judicial bypass for minors, and ultrasounds and fetal heart monitoring before receiving an abortion)

to make the right to abortion de facto nonexistent in many states.[34]

While reproductive law in Turkey lacks a feminist basis and enables the continued instrumentalization of women's bodies through pro- or antinatalist policies, Turkey's commitment to ICPD action plans, the Sustainable Development Goals, and CEDAW has marked a change at the policy level from a population control to a women's right approach, which is monitored by feminist organizations. Under the ICPD Programme of Action, states are expected to take all necessary measures to secure access to health care, including sexual and reproductive health care, and to consider gender equality and women's autonomy in decision making in sexual and reproductive health matters when developing reproductive health programs and population-related programs. The Sustainable Development Goal on gender equality (Goal 5.6) also includes stipulations for the granting of universal access to sexual and reproductive care, including abortion access, stating that governments should not limit access to abortion on cultural or religious grounds. Additionally, CEDAW requires governments to attain gender equality in health care, including family planning services (art. 12), to secure adequate access for rural women on family planning counseling and methods (art. 14(b)).[35] In CEDAW General Recommendation no. 35, denial or delay of safe abortions and forced continuation of pregnancy are considered gender-based violence (Item 18).[36] The results of this study, taken together with those of others, show that the current state of affairs on sexual and reproductive health in Turkey constitutes multiple rights violations in the areas of access to methods, access to information, and respecting and enabling women's autonomy in decision making on reproductive matters.

Feminist monitoring of ICPD, the Sustainable Development Goals, and CEDAW is important. So is the inclusion of women's sexual and reproductive rights in the agenda of the Turkish feminist movement after the 2012 mobilizations. While these provide valuable counter-forces to attempts to curb abortion and reproductive rights, as this paper shows, the neoliberal economic context (with its conservative and increasingly authoritarian dimensions) should also be critically examined, and, ideally, a new law that recognizes reproductive rights as women's rights and not dependent on the state, men, and family, should be passed.

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References

1. C. Mohanty, "Under Western Eyes" Revisited: Feminist Solidarity through Anticapitalist Struggles*, Signs, Vol. 28(2*) (Winter 2003), pp. 499-535.

2. Balsoy, G. E. *Kahraman Doktor Ihtiyar Acuzeye Karsi: Gec Osmanli Dogum Politikalari.* (Istanbul: Can Sanat Yayinlari, 2015).

3. E. C. Ertem, "Anti-abortion Policies in Late Ottoman Empire and Early Republican Turkey: Intervention of State on Women's Body and Reproductivity," *Fe Dergi* 3/1 (2011), pp. 47-55.

4. A. Bugra, & C. Keyder, "The Turkish Welfare Regime in Transition," *Journal of European Social Policy* 16/3 (2006), pp- 211-228.

5. F. Acar, & G. Altunok, "The 'politics of intimate' at the intersection of neo-liberalism and neo-conservatism in contemporary Turkey," *Women's Studies International Forum, V41* (2013): pp. 14-23.

6. Acar & Altunok (see note 5).

7. Hurriyet Daily News, 26 May 2012.

8. Mor Cati, " Kurtaj yapiyor musunuz? Hayir yapmiyoruz" February 3, 2015. https://www.morcati.org.tr/tr/290-kurtaj-yapiyor-musunuz-hayir-yapmiyoruz; Kadir Has University Gender and Women's Studies Research Center, "Legal But Not Necessarily Available: Abortion Services at State Hospitals in Turkey", 2016. https://gender.khas.edu.tr/sites/gender.khas.edu.tr/files/inline-files/Abortion%20English.pdf.

9. M. Lazzarato, *The making of the indebted man*. Translated by Joshua David Jordan. (Amsterdam: *Semiotext(e),* 2012).

10. C. Lapavitsas, "The financialization of capitalism: 'Profiting without producing'", *City 17/6* (2013), pp. 792-805.

11. Lazzarato (see note 9).

12. F. "Bifo" Berardi, *The uprising: On poetry and finance* (Los Angeles, CA: Semiotext(e), 2012).

13. Europe Solidarity Delegation, *Greece the Frontline of Austerity* (April 2013); R. Klein, "Health care reform: The global search for utopia," *British Medical Journal V307* (1993), p. 752.

14. T. Agartan, "Gender and Health Sector Reform: Policies, Actions, and Effects" in S. Dedeoglu & A. Y. Elveren (eds), *Gender and Society in Turkey: The Impact of Neoliberal Policies, Political Islam and EU Accession* (I.B. Tauris, 2012), pp. 155-172.

15. Ç. Keyder, "Giriş" in Ç. Keyder, N. Üstündağ, T. Ağartan, & Ç. Yoltar (eds.), *Avrupa'da ve Türkiye'de Sağlık Politikaları: Reformlar, Sorunlar, Tartışmalar*, (Istanbul: İletişim Yayınları, 2007), pp. 15-35.

16. T. Ağartan, "Sağlıkta reform salgını" in Ç. Keyder, N. Üstundağ, T. Ağartan, & Ç. Yoltar (eds.), *Avrupa'da ve Türkiye'de Sağlık Politikaları: Reformlar, sorunlar, tartışmalar* (İstanbul: İletişim Yayınları, 2007), pp. 37-54.

17. A. Dayi & E. Karakaya, "Transforming the gendered regime through reproductive politics: Neoliberal health restructuring, the debt economy and reproductive rights in Turkey" in A. Kian & B. Turkmen (eds), *Les Cahiers Du Cedref:Transformations of the Gender Regime in Turkey*, n. 22 (2018), pp 158–92. Available at https://journals.openedition.org/cedref/1150.

18. Hacettepe University Institute of Population Studies, "*TNSA: Turkiye Nufus ve Saglik Arastirmasi/Demographic and Health Survey"* (Ankara, 2013).

19. Before the health reform, larger AÇSAP centers in Istanbul, Izmir, Ankara and Diyarbakir, provided abortions. Personal conversation with E. Karakaya, November 24, 2019.

20. UNFPA Birleşmiş Milletler Nüfus Fonu. *Aile Planlaması Hizmetleri ve Kontraseptif Yeterliliği Ulusal İstişare Çalıştayı Raporu*. Ankara, 26.12.2016.

21. C. Topgül, T. Adalı, A. Çavlin, C. Dayan. *Sisteme değil isteğe bağlı hizmet: Sağlık Çalışanları Gözünden İstanbul'da Kürtaj ve Aile Planlaması Hizmetlerinin Durumu*. Nüfusbilim Derneği, Türkiye Aile Sağlığı ve Planlaması Vakfı, UNFPA Türkiye Ofisi. Ankara, 2017.

22. Berardi (see note 12).

23. Z. A. Ocek, M. Cicekliogl u, U. Yucel, & R. Ozdemir, "Family medicine model in Turkey: a qualitative assessment from the perspectives of primary care workers," *BMC Family Practice, V15*/38 (2014), pp. 1-15.

24. Ibid., p. 10.

25. A. Davas Aksan, "Sağlıkta Dönüşüm ve Üreme Sağlığı" in *I. Kadın Hekimlik ve Kadın Sağlığı Sempozyumu Sağlıkta Kadın Emeği Sempozyum Kitabı* (Ankara: TTB Yayınları, 2011), pp. 31-35; TNSA, 2013 (see note 18).

26. Ocek et al. (see note 23); Topgül et al. (see note 21).

27. A. Yavuzyılmaz A, M. Topbaş, B. Orhan, N Kaymaz, U. Köse, G. Çan G., "Kontraseptif Yöntemlerin Maliyeti ve Finansmanı", *Sağlık ve Toplum* 20/2 (2010), pp. 9-13.

28. N. Etiler N and C.I. Yavuz, "Sağlık Reformlarının Ana Sağlığı Hizmetleri Üzerine Etkileri: Ülke Örnekleri", *Toplum ve Hekim* 19/4 (2004), pp. 285-292.

29. UNFPA Turkey. (see note 20).

30. Kadir Has University Gender and Women's Studies Research Center (see note 8).

31. F. Artiran Igde, R. Gul, M. Igde, and M. Yalcin. "Abortion in Turkey: Women in Rural Areas and the Law," *The British Journal of General Practice 550*/58, (2008), pp. 370-373.

32. E. E. Aksit, "Geç Osmanlı ve Cumhuriyet Dönemlerinde Nüfus Kontrolü Yaklaşımları," *Toplum ve Bilim* 117 (2010), pp. 179-197.

33. Ibid; A. Dayi & E. Karakaya (see note 17).

34. Allen Guttmacher Institute. *An Overview of Abortion Laws*, November 13, 2019. https://www.guttmacher.org/state-policy/explore/overview-abortion-laws.

35. Convention on the Elimination of All Forms of Discrimination against Women, 1979. Available at https://www.ohchr.org/EN/ProfessionalInterest/Pages/CEDAW.aspx.

36. General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19. Available at https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/1_Global/CEDAW_C_GC_35_8267_E.pdf.

The Right to Abortion in Tunisia after the Revolution of 2011: Legal, Medical, and Social Arrangements as Seen through Seven Abortion Stories

IRENE MAFFI AND MALIKA AFFES

Abstract

In this article, we explore the effects that Tunisia's post-revolutionary democratization process has had on the right to abortion, drawing on ethnographic material, interviews, and medical files that we collected between 2013 and 2017, as well as the professional experience of one of us. We show that despite the existence of a relatively liberal abortion law for more than 40 years, women in Tunisia have trouble getting abortion care for economic and organizational but also ideological and political reasons. The existence of the abortion law constitutes but one factor among many others that determine women's ability to access abortion services; medical practices and women's abortion itineraries are caught up within complex arrangements that entail multiple socioeconomic and cultural factors, political transformations, the variability of rules in medical and administrative institutions, and contradictory interpretations of the legal apparatus. Examining the abortion itineraries of seven women we met in a large hospital in Tunis, we argue that these abortion itineraries shed light on the ordinary constraints experienced by poor Tunisian women who cannot afford to turn to the private sector. We maintain that attitudes toward the right to abortion in post-revolutionary Tunisia are problematic and that the democratization of local society has brought about unexpected consequences that do not extend but rather reduce women's rights in the domain of sexual and reproductive health.

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Introduction

This article explores the effects of the democratization process in post-revolutionary Tunisia, taking the domain of sexual and reproductive health as our field of study. In particular, we investigate the impact of larger social and political transformations on the right to abortion, drawing on ethnographic material that we collected from 2013 to 2017. We show that the existence of an abortion law is only one factor among many others affecting women's ability to access abortion services; medical practices and women's abortion itineraries are caught up within a complex configuration that entails multiple socioeconomic and cultural factors, political transformations, the variability of rules in medical and administrative institutions, and contradictory interpretations of the legal apparatus. Only by examining the interactions between all of these factors is it possible to understand why in Tunisia—where abortion has been legal for more than 40 years—many women experience physical and moral suffering when they want to abort, and many are forced to resort to illegal abortion.[1] In addition, because of the impossibility of accessing abortion services, more than 1,000 babies are abandoned every year by unmarried mothers.[2]

In the first part of the article, we give a brief overview of the history of abortion in postcolonial Tunisia, focusing on the transformations brought about by the revolution of 2011. We then examine the cases of seven women who sought abortion care in public facilities and the legal, administrative, sociocultural, and medical obstacles they had to face. We argue that their abortion itineraries shed light on the ordinary constraints experienced by poor Tunisian women who cannot afford to turn to the private sector. Their itineraries also show that attitudes toward the right to abortion are problematic in Tunisia and that the democratization of local society has brought about unexpected consequences that reduce—rather than extend—women's rights in the domain of sexual and reproductive health. In conclusion, we consider whether the democratization process that started in 2011 has improved women's access to abortion care or has instead made it more difficult.

Historical overview

Tunisia is the only Arab country where abortion for social reasons has been legal for all categories of women since 1973. The law allows abortion in medical institutions under the authority of physicians until the end of the first trimester for married and unmarried women without marital consent. Minors, however, must obtain the consent of one of their parents or of a legal tutor in order to access abortion services at a public facility. Contraception and abortion care are provided for free in such facilities. Although the law applies to all medical institutions, in the private sector rules about accompaniment and permission for minors are not so strictly respected, and so most women who find themselves in "irregular situations" turn to private clinics or doctors if they can afford them. The decriminalization of abortion dates back to the mid-1960s when, influenced by the neo-Malthusian ideology circulating in the postwar period, the political elite of independent Tunisia considered the reduction of the high fertility rate a priority.[3] For several decades, Tunisian institutions promoted family planning and abortion as practices contributing to reducing the number of citizens and improving their educational and socioeconomic situations with the aim of engineering a modern society.[4] The legalization of abortion and promotion of family planning were the results of a political decision made by a modernist elite rather than the conquest of a women's movement, as in many European countries and North America. Thus, in Tunisia abortion was not introduced as a women's right but as an exception in the section of the Penal Code regulating "murder." Despite the apparent secular character of Habib Bourguiba's rule, to justify the depenalization of abortion (as in other fields), he appealed to the religious tradition rather than to legal or medical arguments. National religious authorities drew on certain opinions within the main legal schools of Sunni Islam to state that abortion is religiously permitted until 120 days after conception.[5]

Precise demographic targets, the centralized and hierarchical structure of the family planning program, and aggressive public campaigns pro-

voked abuses and coercive practices that caused resistance and distrust among the population.[6] Paternalistic attitudes among medical personnel were widespread, and forced contraception and (female) sterilization were common in the early phases of the family planning program, which, above all, targeted uneducated, rural, and poor women.[7] After the demographic transition took place in the late 1990s, the family planning program lost its importance; local authorities and international agencies ceased to focus on it and funds were cut. The emergence of religious conservatism in the early 2000s and the deep political transformations Tunisia went through after the revolution of 2011 have contributed to redefining state policies in the domain of sexual and reproductive health. Although the abortion law has not been repealed in the wake of the revolution—despite the attempts of the Islamist party Ennahdha in early 2013—medical practices have changed over the last 15 years, showing that the legal aspect is only one element among many affecting women's access to abortion care. Social and religious conservatism has become more apparent, state control over medical institutions and personnel much weaker, and the freedom to act according to one's own moral convictions possible, despite the absence of a law regulating conscientious objection.

Even if in 2014 the post-revolutionary Tunisian state dropped all reservations to the Convention on the Elimination of All Forms of Discrimination against Women and reaffirmed equality between men and women in the new constitution, women's access to abortion has become more difficult. Many of the health care practitioners we met did not consider abortion a human or woman's right and believed that offering abortion care is a controversial and morally problematic practice. Terms such as human rights and reproductive and sexual rights were generally absent from the discourses of the practitioners we talked to. This reflects more largely the absence of an international consensus on the definition of abortion as a human right: of all relevant international and regional instruments, only the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2003) recognizes abortion as a human right in specific circumstances. The then Tunisian president Beji Caïdi Essebsi signed the protocol in 2015, but the state ratified it only in 2018.[8]

Tunisia's recent and ongoing dramatic economic crisis has further impoverished the public health sector, in which staff, equipment, and medication were already insufficient before the revolution. According to several of the health professionals working in public facilities whom we interviewed, in the 1990s many regional hospitals, especially those located in western and southern Tunisia, were severely understaffed and most medicines were unavailable. Furthermore, Ibtissem Ben Dridi, who worked in the area of Gafsa in the early 2000s, writes that rural dispensaries were nearly abandoned and medical personnel were scarce during this time.[9] Saïd Ben Sedrine and Monji Amami also note that "since the 1990s, public health services have been undergoing a regression that is causing public health policy to lose its role as a social regulator in the face of disease risk."[10] The end of President Zine El Abidine Ben Ali's rule has also made illegal practices and corruption in medical institutions more frequent and uncontrolled. Cases of contracted doctors working in public medical facilities who redirect patients to their private offices to obtain services has become almost ordinary in the field of contraceptive and abortion care, as recounted to us by many women and health care providers.

As in other countries that have undergone dramatic political transformations, in Tunisia the revolution and the democratization of society have not meant the reinforcement of women's rights in the domain of sexual and reproductive health. In Russia, for example, the case of maternity care reforms after the collapse of the Soviet Union shows that the dissolution of the previous regime and the introduction of the "spirit of democracy" are not sufficient to grant women's rights unless the economic and political organization of health care is transformed.[11] While former regimes in both countries provided primary health services, including sexual and reproductive health services, the collapse of the system of power brought about new inequalities and made access to health

care more difficult. The (re)emergence of religious conservatism in post-revolutionary Tunisia and in post-Soviet Russia—and in several other Eastern European countries, such as Poland—is also a common feature.[12] In these countries, the questioning of women's reproductive and sexual rights has been fueled by political actors advocating religious arguments or by religious authorities themselves, such as the Catholic Church.

Methodology

Before examining the abortion itineraries of seven women, we would like to stress that this article is the result of a research collaboration between Malika Affes, a midwife who has been working in Tunisian public facilities for more than 20 years, and Irene Maffi, a social anthropologist based in Switzerland studying reproductive and sexual health in the Arab world.[13] Our analysis draws on participant observation, the examination of medical files, interviews with women and health care providers, and the personal experience of Affes as a practitioner involved in abortion services.

Maffi conducted fieldwork between August 2013 and June 2014 and went on to collect ethnographic material until January 2018 by making short trips to Tunisia and reading the publications of local institutions and the media. Participant observation and interviews took place in one government hospital in Tunis and three public sexual and reproductive clinics in the area of Great Tunis, which includes four governorates. Affes has been in charge of the family planning unit of a large maternity hospital in the capital for 12 years. She has directly experienced the transformations of the national reproductive policies and the financial crisis of the government health sector. She has been an actor and a witness in the abortion itineraries we describe in the reminder of this article. To write the article, we combined Affes's medical, legal, and institutional expertise and Maffi's anthropological knowledge. We decided to base our analysis on a few selected cases that, in our opinion, are qualitatively representative of the abortion itineraries of many Tunisian women and give an accurate picture of the public health care system in the region of Great Tunis. However, the ethnographic material we use does not allow for an overview of the abortion trajectories of women from other regions, especially those living in southern and western rural areas.

Permission to conduct research was obtained from the Ministry of Health and the Office National de la Famille et de la Population, the Tunisian agency in charge of sexual and reproductive health services. At the time of our research, no ethics committee existed at the University of Lausanne, and therefore we could not get an approval from this institution.

Abortion itineraries

Lina[14]

It was early March 2014 when Lina, a 16-year-old girl, came to the family planning unit of Hospital T, a large maternity hospital in Tunis, accompanied by two female guards of a detention center located in the capital. She had been arrested for illegal prostitution and was 13 weeks pregnant. She wanted to terminate the pregnancy, but her situation was extremely complicated because she was incarcerated, was a minor, and carried a late-first-trimester pregnancy. According to the law, Lina needed to obtain the consent of one of her parents or of a legal tutor to access an abortion. In her case, her parents were not involved in her life, and therefore the judge had to make the decision. The process took several weeks because when Lina first came to the hospital, the judge urged the head of the obstetrics and gynecology department to make the decision, refusing to take the responsibility for the decision himself. After a few weeks of uncertainty during which the doctor and the judge passed the buck to each other, Lina eventually obtained permission to terminate the pregnancy. However, her tribulations were not finished, because the social service department had refused to register her at the family planning unit. The opposition of the social workers was related to the fact that legally, Lina no longer had the right to get an abortion: at this point, she carried a second-trimester pregnancy. It was thus

necessary to resort to a psychiatrist, who wrote a medical certificate attesting that Lina's mental health was at risk and that she needed a therapeutic abortion. But because she was a minor and pregnant, there was yet another procedure that she had to undergo before getting abortion care. Tunisian law criminalizes sexual relationships with minor women even if they consent to it; if a girl under 18 is pregnant, the police must initiate a criminal investigation to identify the man responsible for the pregnancy. Therefore, Lina had to undergo an amniocentesis before getting abortion care so that the police could carry out a DNA exam, even if it was almost impossible to identify the offender.

Lina's case shows that social inequality and vulnerability, a lack of coordination between legal and medical public institutions, administrative rules, and the contradictory effects of various laws can generate bureaucratic violence and moral and physical suffering against young girls who seek abortion services. The interference of the actions of several individuals and institutions determined a specific management of time, shaping Lina's abortion itinerary and personal experience.

Dalenda

Dalenda, a 17-year-old girl from Tunis, came to the hospital for the first time at the end of November 2013, accompanied by her father. She was 12 weeks pregnant and wanted an abortion. Her father gave his permission for the abortion, but Dalenda needed to meet a social worker first and undertake a few medical tests. Like Lina, she needed to undergo an amniocentesis to identify the DNA of the genitor of the embryo. But in Hospital T, women must wait until 14 weeks of pregnancy to undergo an amniocentesis. No other methods to collect the genetic material of the embryo (such as chorionic villus sampling) were available, meaning that Dalenda was forced to experience a long and excruciating waiting period and, subsequently, a painful medical abortion, as the fetus had become quite large. Indeed, at the time of her abortion, resident doctors did not want to resort to the technique of aspiration, which can typically be used during early pregnancy.

In Dalenda's case, the social service department did not request the intervention of the police, for reasons we will ignore. The midwife in charge of abortion asked Dalenda's father to quickly pay for the blood group test required before undergoing medical abortion so that his daughter would not exceed the three-month legal limit for abortion. The following day, Dalenda came accompanied by a woman in her fifties, probably a neighbor or a relative, as we learned that the girl's mother had died many years before when giving birth to her. Dalenda was hospitalized for the medical abortion because, according to local medical protocols, after nine weeks of pregnancy the procedure cannot take place at home. She was given tablets of misoprostol and had to stay in a room with several women who had recently given birth or were about to deliver their children. A few hours after her hospitalization, we went to visit her in the ward to see how she was doing: Dalenda was crying silently in one corner, alone, under the apparently indifferent gaze of the women sharing the room with her. A health provider approached her and tried to encourage and comfort her. The provider was moved by Dalenda's situation: as a child, the youngest of 10, Dalenda was neglected; when she became pregnant (allegedly after having sex with a much older man), her father drove her out of the house and she took refuge in one of her sisters' house.

Dalenda's fragmentary story shows how hospital organizations and administrative procedures can disregard the rights to privacy and protection to which a young girl is legally entitled: she was not offered a private room and could not have a companion, instead being forced to share a room with married mothers hospitalized for the birth of their children, whereas she was unmarried and subject to moral condemnation. As a provider once told an unmarried woman who had to be hospitalized to undergo medical abortion, "Do not look at the way people look at you, do not listen to what they tell you; ignore them! I am the person in charge of you and I respect you; I respect your freedom and your rights." These recommendations were motivated by the practitioner's awareness that many providers in the Tunisian public sector fail to show respect for

unmarried pregnant women because social norms proscribe premarital sexual activity.[15]

Ahlem

In December 2016, several articles were published in the Tunisian newspapers reporting the case of a 13-year-old girl residing in a rural area in the northeast of the country who was going to marry her rapist, a 20-year-old relative. The girl was pregnant, and the families had tried to find an arrangement to preserve their reputations. Until 2017, article 227 bis of the Penal Code allowed rapists to avoid being incriminated if they married their victim, regardless of the victim's age. Before asking a judge to authorize the marriage, Ahlem's mother went to Hospital T because she wanted her daughter to abort and keep the event secret, as she feared that were the story to become public, it would ruin her personal reputation. She was ready to sacrifice Ahlem's right to bodily integrity to avoid social reprobation and shame. When they arrived at the hospital, the girl's mother asked the health care personnel to provide an abortion without initiating the administrative and legal procedures required by law. She did not want to go through the social service department because it would report the case to the Brigade for the Protection of Minors. When the health provider received Ahlem and her mother, the girl kept playing with the door of the cupboard as if she were not concerned by the situation. Since the health provider refused to provide the abortion unless Ahlem followed the required procedures, the mother left the hospital with her daughter and never came back. Because it was socially shameful for the mother to file a complaint in court—an act the social service department of the hospital would demand—the mother and her family eventually decided to organize the marriage with the rapist and let her daughter keep the pregnancy.

Ahlem's story shows that sociocultural norms interact with the law in complex ways. The legal procedure that was required in Ahlem's case drove the mother and her family to accept the marriage instead of protecting the girl. Ahlem's mother's behavior can be understood when we consider that even in cases where the victim is not a minor, the woman often gets an abortion and does not report the rape in order to avoid the scandal.

Sumaya and Maissa

Sumaya, a woman from Ben Arous, was 25 years old and had married in February 2017, three months before coming to the hospital. Because she had signed the marriage contract, she was legally and religiously the wife of her spouse. However, in Tunisia, a marriage contract is not considered to be socially relevant until the wedding ceremony takes place. Thus, since Sumaya had not yet celebrated the wedding when she registered at the hospital reception desk, the employee refused to acknowledge her legal status and sent her to the social service department, where all unmarried women must undergo an interview about the circumstances of their pregnancies. Although an adult and married, Sumaya could not get abortion care without submitting to the specific procedures that the Tunisian state applies to unmarried women.

Like Sumaya, Maissa was from Ben Arous and came to Hospital T in May 2017. A 17-year-old high school student, she was already married but could not get abortion care without first going to the hospital's social service department. She had to undergo the procedures required of minor women even though, according to Tunisian law, she should legally be considered an adult. The social service department asked for the consent of Maissa's husband and of her mother before authorizing her to receive abortion care. This was a double infringement of Maissa's rights, for in Tunisia, women may receive an abortion without the husband's consent and, if married and an adult, do not need a legal guardian to take responsibility for this act. Also problematic was the fact that Maissa needed to end the pregnancy to complete her studies because the Ministry of Education does not allow students to attend school while pregnant. Maissa's rights to education and to reproductive freedom were thus in contradiction, a situation that forced her to make a decision that was not necessarily in accordance with her or her husband's wishes. These two cases show not only that the legal apparatus sometimes produces contradictory situations but also that

actors apply the law by adapting it to their moral and social interpretations of a woman' trajectory, violating the rights that legal norms are supposed to protect.

Sara

Sara, a high school student from Melassine who was almost 18 years old, was hospitalized in Hospital L for a fever and cervical and inguinal lymphadenopathy in March 2017. Without requesting her legal guardian's consent, health providers decided to submit Sara to several tests for sexually transmitted infections, including HIV, and an etiologic investigation. They also performed a gynecological exam during which they detected a nine-week pregnancy. As written in the referral letter sent to the providers of Hospital T, her case was reported to the social service department and the Brigade for the Protection of Minors. She was transferred to Hospital T because Hospital L does not offer abortion services like most government hospitals in the country despite the law mandating them. When Sara met the practitioner in charge of abortion care, she claimed that she went to Hospital L for her health disorders rather than for abortion care. She did not understand why the providers at Hospital L wanted her to terminate the pregnancy when she had not requested it. She stated that she wanted to be free to make her own decisions and refused to follow the legal procedures required by the law in the case of a pregnant woman under 18. The health provider was surprised by Sara's story and shared her feelings of being caught up in a mechanism in which she was deprived of agency. Medical logic seemed less important than social logic in the way Hospital L's health care providers shaped Sara's therapeutic itinerary. Sara was supposed to come back to the hospital after several weeks to undergo the amniocentesis aimed at identifying the DNA of the genitor. Her father signed the consent for abortion, but she never came back. She had probably already planned an abortion in the private sector, where legal procedures never take place. Most private clinics and doctors in Tunisia provide abortion care without investigating the circumstances of the woman's pregnancy, marital status, or age. This means that girls and women who can afford to turn to the private sector do not have to go through the same social and legal procedures and thus have more rights than women who cannot. Providers in the public and private sectors do not apply the law with the same rigor, generating discriminations that mark socioeconomic and regional divides. Other inequalities also exist between women from rural areas and from central and southern Tunisia and women living in the capital or in the major coastal cities. The former have to travel to the capital or the larger coastal cities if they want to get abortion care because this service is usually not available in the areas where they live. In some cases, even if abortion services are available, unmarried women who can afford it choose to travel to another city, as they are afraid to be seen by family members or acquaintances if they attend the government clinic of the city where they live.[16]

Fawziyya

Fawziyya was a 30-year-old woman who lived in a small city located 200 kilometers from Tunis. She was married, did not have a job, and belonged to an underprivileged social milieu. In June 2015, she came to Hospital T to get an abortion, declaring that she was not married because, as she confessed, she thought that it was the only way to avoid involving her husband in the decision. Fawziyya was unaware that the law does not require a husband's consent for an abortion. The employees of Hospital T's social service department wanted to investigate why, at her age, she was not married and asked for her birth certificate, on which marital status is indicated. When they realized that Fawziyya was married, they immediately suspected that the pregnancy was the result of an extramarital relationship and that she was seeking an abortion out of fear that her husband would find out about the affair. Moreover, the social workers

of Hospital T required Fawziyya to pay out of pocket for a sonogram in a private doctor's office in order to date the pregnancy and be sure that she was not already beyond the legal term to receive abortion care. Fawziyya did not know that she was entitled to receive all medical services in the public hospital and that asking her to undergo an ultrasound in the private sector constituted a violation of her rights. Fawziyya's story is not uncommon in that most women are unaware of the law and accept abusive requests by health care providers or other categories of actors working in the public health sector such as social workers and secretaries. Social rules and moral judgments interfere with the law and hospital rules, pushing some employees of the public health sector to misinterpret the law and infringe on legal norms. Women who resort to public facilities usually lack the financial means to obtain an abortion in the private sector. There is thus a fundamental asymmetry between patients and health care providers in the public sector that allows the latter to exert a power that can seldom be opposed by the former if they want to obtain the desired services. Interference in women's lives can be very detrimental, as health practitioners can deny them abortions or make their abortion itineraries excruciating.[17]

Conclusion

The abortion stories narrated above uncover several prevalent practices and attitudes among health professionals in Tunisia's public sector in the wake of the 2011 revolution. First, they show that despite the existence of a relatively liberal abortion law, women in Tunisia have trouble getting abortion care not only for economic and organizational reasons but also for ideological and political ones. The predicaments of the public health system that appeared as early as the mid-2000s have become more apparent in the aftermath of the revolution and the political and economic crisis that it has spurred.[18] Religious and moral attitudes requiring women to follow tortuous abortion itineraries have become more common, refusal to offer abortion care has become a reality in many public hospitals, and travels to obtain abortion services have become necessary since many regional hospitals and family planning clinics no longer offer them.

Second, the decriminalization of abortion enacted by Tunisia's first president in an effort to achieve the desired demographic goals of the independent state was and remains an object of religious, moral, and social contention in medical settings.[19] In Tunisia, as in many European countries where abortion has been legal for decades, women's right to abortion is not unchallenged because pro-life groups, religious institutions, and nationalist pronatalist movements constantly threaten its legitimacy.[20] Although Tunisia's 1973 decriminalization of abortion drew on Islamic legal opinions that allow abortion until 120 days after conception, the Malekite tradition—which is dominant in the Maghreb—prohibits pregnancy termination, as do the other Islamic opinions that have begun to circulate in the country after the revolution of 2011. Many women and health care providers oppose abortion because they consider it *haram* (religiously illicit). Practitioners use religious or moral arguments to justify their refusal to offer abortion care, ignoring the law and the discourse of rights. Interestingly, however, when in January 2013 Najba Berioul, a deputy of the Islamist party Ennahdha, tried to re-criminalize abortion, she claimed the right of the fetus to be born, an argument typical of European and American anti-abortion movements rather than of the Malekite or other Islamic discursive traditions.

Third, the abortion stories we highlight show that strong social control is exerted on women who seek abortion care in the public health sector. Not only does the state impose specific devices to surveil and control women's sexual and reproductive behaviors, but the personnel of public hospitals and clinics interpret and bend legal rules in accordance with their

personal convictions. The idea that abortion is exceptional, morally despicable, and a transgression of ordinary feminine identity was expressed by many of the health practitioners we interviewed, who turned women who abort into pathological subjects. Therefore, women who are legal adults or married are often treated like minors or unmarried individuals, making their abortion itineraries longer and more painful. The pre-revolutionary legal apparatus that was still in use during our period of study (2013–2017) regulated the domain of sexuality and reproduction according to patriarchal principles under which the control of women's sexuality is much stricter than that of men's, especially as it concerns the conduct of unmarried and minor women. The relevance of these laws—which largely reflect existing social norms—affected the provision of abortion care in the public sector, such as with regard to the treatment of minors seeking abortion services. Even though a law was promulgated in 2010 lowering the age of majority for women from 21 to 18, many health providers at Hospital T, the regional delegate (*mandub jihawi*), and the Brigade for the Protection of Minors went on to apply the ancient law in the initial years after the revolution. Thus, women between the ages of 18 and 20 were forced to go through the procedures designed for minor women that, as mentioned, imply a stronger interference by the state and the family. Overall, it must be emphasized that because most women seeking abortion care in the public sector are unaware of their rights, they are unable to oppose health providers' refusal to offer them the required services.

Fourth, a lack of coordination between the police, the legal system, and the medical sector makes the abortion experiences of some groups of women—especially prisoners, minors, and the unmarried—very difficult. These women are subject to structural and institutional forms of violence that increases their social suffering.[21] Already marginalized and poor, and often with only primary education, prisoners and minors in particular are abused by malfunctioning medical and legal systems that are paradoxically intended to protect them.

To sum up, the revolution has reinforced some attitudes and practices already present in the previous period on account of political instability, rising religious conservatism, a lack of financial resources (leading to shortages of health equipment and personnel), and a growing reluctance to offer abortion care in many public hospitals and family planning clinics. Class and regional divides have become more visible: women who live in the capital and coastal cities, as well as women from the middle and upper classes, enjoy a greater chance of their sexual and reproductive rights being respected compared to women who live in rural areas or in the cities of the interior. In addition, the private sector is gaining ground over the public sector, where abortion services are more and more difficult to get. This reflects a larger trend in which the public health care system is being increasingly neglected and the private sector is on the rise, thanks in part to the medical travels of patients coming to Tunisia from neighboring countries.[22]

References

1. S. Hajri, S. Raifman, C. Gerdts, and D. Greene Foster, "This is real misery: Effects of being denied legal abortion on women's lives in Tunisia," *PLoS ONE* 10/12 (2015), p. e0145338; S. Raifman, S. Hajri, C. Gerdts, and D. Foster, "Dualities between Tunisian provider beliefs and actions in abortion care," *Reproductive Health Matters* 26/52 (2018), pp. 47–57; I. Maffi, "L'interruption volontaire de grossesse en Tunisie après la révolution: Considérations sur l'émergence de nouvelles formes de subjectivité," in C. Fortier and S. Monquid (eds), *Femmes et révolutions en Islam, au Maghreb et au Moyen Orient* (Paris: Karthala, 2017); I. Maffi, "Abortion in Tunisia after the revolution: Bringing a new morality into the old order," *Global Health Journal* 13/6 (2017), pp. 680–691.

2. R. Boukhayatia, "Tunisie: Près de 1000 naissances hors marriage en 2014, un chemin semé d'embuches pour les mères célibataires," *HuffpostMaghreb* (December 16, 2015); S. Mourad, "Tunisie: Arrestation dans la Médina de Tunis d'un médecin pratiquant des avortements clandestinement," *Tunisie Numérique* (October 18, 2017).

3. F. Sandron and B. Gastineau, *La transition de la fécon-*

dité en Tunisie (Paris: L'Harmattan, 2000).

4. Maffi, "Abortion in Tunisia" (see note 1).

5. G. K. Shapiro, "Abortion law in Muslim-majority countries: An overview of the Islamic discourse with policy implications," *Health Policy and Planning* 29 (2014), pp. 483–494.

6. A. M. Foster, *Women's comprehensive health care in contemporary Tunisia* (PhD dissertation, University of Oxford, 2001); N. Gueddana, "L'expérience du programme tunisien de planification familiale," in J. Vallin, T. Locoh (eds), *Population et développement en Tunisie: La métamorphose* (Tunis: Cérès Editions, 2001).

7. Association Tunisienne des Femmes Démocrates, *Le droit à l'avortement en Tunisie: 1973 à 2013* (Tunis: World Social Forum, Oxfam, and CSBR, 2013).

8. C. Zampas and J. M. Gher, "Abortion as a human right: International and regional standards," *Human Rights Law Review* 8/2 (2008), pp. 249–294.

9. I. Ben Dridi and I. Maffi, "De nouvelles économies morales des mœurs? Femmes, professionnels de santé et régimes discursifs en Tunisie," *L'Année du Maghreb* 18/1 (2018), pp. 71–91.

10. S. Ben Sedrine and M. Amami, *La gouvernance du sytsème de santé publique aggrave l'inégalité sociale face au risque de la maladie en Tunisie* (Tunis: Friedriche Ebert Stiftung, 2016).

11. M. Rivkin-Fish, *Women's health in post-Soviet Russia: The politics of intervention* (Bloomington: Indiana University Press, 2005), p. 42.

12. J. Mishtal, *The politics of morality: The church, the state and reproductive rights in postsocialist Poland* (Athens: Ohio University Press, 2015).

13. See, for example, I. Maffi and M. Affes, "La santé sexuelle et reproductive en Tunisie: Institutions médicales, lois et itinéraires thérapeutiques des femmes après la révolution," *L'Année du Maghreb* 17/2 (2017), pp. 151–168.

14. All names are pseudonyms.

15. See, for example, N. Amroussia, I. Goicolea, and A. Hernandez, "Reproductive health policy in Tunisia: Women's right to reproductive health and gender empowerment," *Health and Human Rights* 18/2 (2016), pp. 183–194; see also I. Maffi, D. Delanoë, and S. Hajri, "La santé sexuelle et reproductive, champ d'exercice et d'affrontement des dominations de genre et de classe," *L'Année du Maghreb* 17/2 (2017), pp. 9–19.

16. A. Gherissi and F. Tinsa, "Les services de Santé Sexuelle et Reproductive en Tunisie : Rsultats d'une recherche qualitative auprès des jeunes usagers," *L'Année du Maghreb* 17/2 (2017), pp. 133–150.

17. Hajri et al. (see note 1); Raifman et al. (see note 1); Maffi, "L'interruption volontaire de grossesse" (see note 1); see also Ben Dridi and Maffi (see note 8).

18. Association Tunisienne des Femmes Démocrates (see note 7).

19. L. Labidi and L. Çabra Hachma, *Sexualité et tradition* (Tunis: Dar Annawras, 1989); I. Maffi, *A revolution for women? Sexual and reproductive health, dissention and moral dilemmas in democratic Tunisia* (New York: Berghahn Books, forthcoming).

20. S. De Zordo, J. Mishtal, and L. Anton, *A fragmented lanscape: Abortion governance and protest logics in Europe* (New York: Berghahn Books, 2017).

21. P. Farmer, "On suffering and structural violence: A view from below," *Daedalus* 125/1 (1996), pp. 261–283.

22. See, for example, M. Lautier, *Le développement des échanges internationaux de service de santé: Perspectives des exportations en Afrique du Nord*. Available at http://www.afdb.org/fr/news-and-events/article/international-developmentof-health-services-north-africas-export-prospects-/; B. Rouland, M. Jarraya, and S. Fleuret, "Du tourisme medical à la mise en place d'un espace de soins transnational: L'exemple des patients lybiens à Sfax (Tunisie)," *Revue francophone sur la santé et les territoires (2016), pp. 1–21.*

EDITORIAL

Progress toward Decriminalization of Abortion and Universal Access to Safe Abortions: National Trends and Strategies

MARGE BERER AND LESLEY HOGGART

This special section of the *Health and Human Rights Journal* captures a particular historical moment in the world of abortion law, policy, and practice, which is a constantly changing space. In the countries and regions covered in the papers in this special section—Chile, Colombia, East Africa, Gabon, Gambia, India, Ireland, Latin America, South Korea, and the United Kingdom—changes have been happening or are anticipated, some of them momentous.

The constant possibility of change—due to a change of government, for example—underlines the importance of advocates, abortion providers, legal experts, and academics working together to gain a critical mass of support. This must reach from the grassroots through to national leadership in order to achieve two complementary goals: (1) decriminalization of abortion and (2) universal access to safe abortion and life-saving treatment for complications of unsafe abortion. Though in the short term these may be achieved only partially, we are always aiming for things to get better in each year that passes. Looking back 100 years, we can say that we are succeeding, though painfully slowly, and with setbacks arising from organized opposition.

Recent successes analyzed here have been in very different contexts and have involved different politics: for example, South Korea, Chile, and Ireland. Sunhye Kim, Na Young, and Yurim Lee's paper argues that framing abortion as reproductive justice in South Korea contributed to the 2019 ruling by South Korea's Constitutional Court that the ban on abortion was unconstitutional. They argue that the Joint Action for Reproductive Justice, initiated in 2017 by an organization for women with disabilities, was instrumental in shifting the discourse on abortion from a pro-choice/pro-life binary toward one supporting reproductive justice for all. The paper posits that by shifting the discourse related to reproductive issues, the movement had a stronger position in the legal fight against the state and was able to establish solidarity with other human rights organizations and groups.

For Ireland, Anna Carnegie and Rachel Roth's paper charts the path to abortion law reform from the perspective of grassroots activists in the Abortion Rights Campaign, and then goes on to analyze the legislation enacted as a result of the 2018 referendum victory. The paper highlights the national and inter-

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national policy mechanisms and recommendations that activists leveraged to bring Ireland's abortion regime to the point of reform, pointing, for example, to the 2010 European Court of Human Rights ruling in favor of three women who challenged Ireland's abortion law (known as the ABC judgment).[1] They also point to the power of challenging abortion stigma as a mobilizing call for the public and politicians. They go on to argue, however, that while the substantial changes introduced by the new law are a momentous step forward, it also establishes a needlessly cumbersome regime that remains grounded in a criminal law framework and incorporates barriers (such as a 12-week time limit) that have no grounding in medical evidence. Hence, a significant number of women are still forced to travel to Great Britain for abortions.

Chile is another example. Until 2017, Chile was one of the few countries left that did not permit abortion under any circumstances. Gloria Maira, Lidia Casas, and Lieta Vivaldi show that despite a significant change in the law in 2017—which permits abortion only when the woman's life is at risk, when there are fetal anomalies incompatible with life, and in the case of rape—many women are still forced to have illegal abortions because these limited grounds exclude the reasons for their abortions. The paper raises important questions about whether it is the right thing to do to support a very limited law when no other alternative is offered, or whether it is better to hold out until a better option can be put forward, not knowing whether or when that might happen. There are no easy answers.

The papers thus illustrate how breakthroughs in legal reform—which may be vitally important—are invariably not the end of the struggle. This will certainly remain the case while abortion is still criminalized in any way. Arguably, locating abortion within the criminal law also opens the door to anti-abortion activism, often seeking to limit grounds for abortion or attacking women's reproductive autonomy altogether. In their paper, Pam Lowe and Sarah-Jane Page, based on ethnographic research in the United Kingdom, show how anti-abortionists have attempted to co-opt and use rights-based claims in their arguments against abortion. This paper is important in analyzing anti-abortionists' own words to explain why they do not succeed and how their arguments nonetheless continue to be framed by religious beliefs. The paper ends by suggesting that the right to freedom of belief is a qualified right that should not be drawn upon to damage or limit the rights of others. In respect to abortion, therefore, while activists have the right to hold anti-abortion views, they do not have the right to harass, intervene, or block the path of women who are accessing abortion services.

Why decriminalization?

Because the aim of all criminal abortion laws is to restrict or deny sexual and reproductive autonomy. Globally, almost everywhere, abortion is still punishable in the criminal law, though with exceptions. These exceptions (specific legal grounds) may make only a very restricted number of abortions legal, or they may allow most abortions. This differs from one country to the next in spite of the fact that women's needs are universal. Most of these laws also set an upper time limit on the number of weeks of pregnancy beyond which abortion is not permitted and is punishable. Both these ways of restricting abortion serve to restrict reproductive autonomy. Many countries' laws, such as Great Britain's, contain both kinds of restrictions. Some countries specify certain legal grounds but do not state an upper time limit; however, in many of these cases it is understood that abortion providers may not go beyond an accepted time limit, often not beyond the first trimester of pregnancy.[2] In very few jurisdictions—Canada, for example—abortion has been decriminalized entirely through a court judgment, yet restrictions on access apply there too, as many areas of the country have no abortion services.[3] Thus, whatever the law, issues with provision and access may pertain.

Why universal access to safe abortion and treatment for complications of unsafe abortion?

Because every woman has the right to life and health.

As long as abortion remains a crime, it damages women who need abortions and threatens providers willing to help them, though in different ways and to different degrees. Many papers in this special section not only explore these different realities but also demonstrate how these can be contested and changed through activism. Aimée Patricia Ndembi Ndembi, Justine Mekuí, Gail Pheterson, and Marijke Alblas show the positive potential of midwives who provide post-abortion care in medical institutions in a radical and subversive manner. Research by Le Réseau d'Afrique Centrale pour la Santé Reproductive des Femmes: Gabon, Cameroun, Guinée Équatoriale (Middle African Network for Women's Reproductive Health), which they founded in 2009, showed that the main obstacle to providing effective post-abortion care was the lack of emergency skills among midwives as first-line providers. They thus designed a training program for midwives in manual vacuum aspiration, misoprostol protocols, and the insertion of copper IUDs. To date, the network has trained more than 500 hospital practitioners in Gabon in manual vacuum aspiration, leading to important decreases in treatment delays, with corresponding decreases in mortality from abortion complications. This direct-action strategy circumvents restrictive abortion laws by the provision of expert assistance. The authors are right to believe that services cannot await legal reform. However, they do also advocate for the decriminalization of abortion—and while they were completing their paper, abortion law reform was announced in Gabon (details unclear at this writing), which the authors played an important part in achieving.[4]

Other papers explore different strategies for changing the discourse on abortion. Ximena Casas, for example, describes a multidimensional strategy developed by Planned Parenthood Global, whose long-term aim is to ensure that legal abortion is universally available and accessible to girls aged 9–14 who have been raped. The strategy includes research, communications, litigation, and advocacy work. As part of this, they launched the advocacy campaign "Niñas, No Madres" ("Girls, Not Mothers"), which is now supported by a Latin American-wide coalition of 45 organizations. The campaign draws on case histories of girls aged 9–14 who have been raped by family members or acquaintances, who were denied legal abortions, and, in many cases, who have received no justice since. They are now working with groups in several countries in the region to litigate the cases of four girls, described in the paper, to have their rights recognized and receive reparations. Their work shows that forced pregnancy and motherhood seriously damage girls' physical, emotional, and psychological health; violate their rights to health, education, and information; and upend their life plans.

Changing political contexts—as well as activist action—also open up new opportunities. In the Gambia, for example, the colonial imposition of a Gambian version of the UK's 1861 Offences against the Person Act was inserted in the Gambian Penal Code in 1933 and has not been revised since. It was only when an international conference was due to be held in the Gambia that an effort was made to reform the law to include some women's rights. Yet, as argued by Satang Nabaneh, the current shift from an authoritarian regime to a democratic one provides an opportunity for legal mobilization to advance women's sexual and reproductive rights, including broadening the legal grounds for abortion to the extent that they might be achievable. In order to achieve this, the paper calls for collaborative networking among parliamentarians, health professionals, human rights activists, the media, and women's rights supporters. Although many Gambian women's groups have not yet felt comfortable supporting abortion rights, a conference in 2019 bringing together a wide range of actors, organized by a young women's group, has now opened up this conversation and is challenging this stance.

Legal experts' involvement in addressing the consequences of criminal laws on abortion is varied, and innovative projects are developing rapidly in many countries. The paper by Ximena Casas, Mitchelle Kimathi-Osiemo, Dee Redwine, Claire Tebbets, and Karen Plafker describes and analyzes the formation of the Legal Support Network (LSN), an initiative by Planned Parenthood Global in conjunction with national lawyers in several Latin

American and East African countries, from a feminist perspective. The paper argues that, although in the long term, fully overcoming obstacles to the provision of legal abortion requires the transformation of gender norms, in the short term, the negative impact that restrictive laws have on abortion providers and those who require abortions can be mitigated and circumvented with legal support. National LSN groups look to bypass the oppressive consequences of restrictive abortion laws. At the heart of their method is the prevention of harassment of women and abortion providers who have been threatened with prosecution. The paper argues that such prevention work in support of safe abortion providers is effective in reducing police harassment, offering providers the information and skills they need to stand up to intimidation, and helping to keep safe abortion services available to those who need them.

Women's wide-ranging needs and realities

Examination of the consequences of legality or illegality of each of the six main grounds for abortion forces a focus on the particular categories of women and girls affected—from those who become pregnant due to their husbands' refusal to allow contraception, to those who have been raped, sometimes repeatedly, to those whose life would be at risk if the pregnancy were continued, to those whose pregnancy is wanted but is non-viable.

Although probably the most common reasons for seeking abortion are related to a range of social and economic reasons—such as young age, single status, and being unable to support a(nother) child—too many laws are interpreted to allow abortions only if there is an immediate risk to the woman's life and in cases of serious risk to her health, serious or fatal fetal anomaly, and rape. While having these grounds is far better than having none, it also means that only a small number of the women seeking abortions will be considered eligible and able to access abortion in public health care services. Too often, moreover, women are denied abortions they are entitled to, and in some cases because they present for abortion after the legal time limit. In their paper, Padma Bhate Deosthali and Sangeeta Rege show that safe abortions are being denied to survivors of rape in India even though domestic laws place a legal responsibility on the health care system to offer immediate care and treatment, including legal abortion, to anyone who has been subjected to rape. Their paper provides case histories of survivors of marital rape, acquaintance rape, and rape during childhood who have nonetheless been refused abortions in several public hospitals in Mumbai, and describes the enormous damage inflicted on them by having to continue those pregnancies. Much of the problem arises because the abortion law permits abortions only up to 20 weeks of pregnancy, and many women (and especially children) in this situation do not seek help until too late. But marital rape survivors are denied abortions even if they come before 20 weeks. Doctors feel restricted by the law and may also not understand the repercussions women suffer. Courts are then approached to intervene, though this is not a requirement. This often exacerbates the problem by creating long delays—and even then, it still does not always lead to an abortion being permitted. The authors make a strong case for upholding the legal framework for access to safe abortion following rape, including marital rape, and for holding doctors accountable for the provision of timely abortion services.

Limited grounds mean women having to pay a lot of money for a private sector abortion in secret or having to go through an unsafe abortion. Hence, the broader the legal grounds—and the later in pregnancy that abortion when needed is allowed—the more likely it is that most (or all) girls and women will be able to access safe abortions. Given that an average of one in four pregnancies ends in an induced abortion, we are talking about the consequences for the health and lives of a very high number of women and girls every year—some 56 million annually as of 2010–2014.[5]

In too many parts of the world, breakthroughs have been years, if not decades, in the making and are few and far between. Ana Cristina González-Vélez, Carolina Melo-Arévalo, and Juliana Martínez-Londoño show this in Colombia, where

nearly 13 years of sustained and continuous efforts to ensure the implementation of the legal grounds for abortion approved by the Constitutional Court in 2006 have not resulted in great advances. Today, less than 1% of abortions in Colombia are legal. To challenge this stasis and move forward, they propose a strategy for change based on the complete decriminalization of abortion as a "just cause"—that "no woman should be imprisoned or otherwise punished for having an abortion, and that no health care provider should be imprisoned or otherwise punished for providing safe abortion services at the woman's request, or for providing abortion-related information." They draw on the concept of biolegitimacy, a concept first developed by Didier Fassin, which is about the importance not only of women's biological lives but also their biographical lives, to explain why human rights belong only to those who have been born. They argue that only "without the crime of abortion, without the legal grounds, without the stigma, without legal coercion or regulation, and with the normalization of abortion care as a regular health service [can we] begin to transform the terms of the debate and to conquer our right to abortion and, by extension, our right to full gender equality."

As the guest editors of this powerful collection of papers, we can only agree wholeheartedly with this politically charged conclusion.

References

1. European Court of Human Rights, A*, B and C v. Ireland*, Communication No. 25579/05 (2010).

2. R. Boland, "Second trimester abortion laws globally: Actuality, trends and recommendations," *Reproductive Health Matters* 18/36 (2010), pp. 67–89.

3. C. Kaposy, "Improving abortion access in Canada," *Health Care Analysis* 18/1 (2010), pp. 17–34.

4. P. Boukika, "Gabon: Le gouvernement légalise l'avortement," *Gabon Media Time* (November 5, 2019).

5. S. Singh, L. Remez, G. Sedgh, et al., *Abortion worldwide 2017: Uneven progress and unequal access* (March 2018). Available at https://www.guttmacher.org/report/abortion-worldwide-2017. See also World Health Organization, *Preventing unsafe abortion: Policy brief* (Geneva: World Health Organization, 2019). Available at https://apps.who.int/iris/bitstream/handle/10665/329887/WHO-RHR-19.21-eng.pdf?ua=1.

Eliminating Abortion from Criminal Law in Colombia: A Just Cause

ANA CRISTINA GONZÁLEZ-VÉLEZ, CAROLINA MELO-ARÉVALO, AND JULIANA MARTÍNEZ-LONDOÑO

Abstract

The two main legal models governing abortion provision, indications for abortion and time limits on the number of weeks of pregnancy, both limit recognition of women's reproductive autonomy. Each model restricts the circumstances under which women can access abortion. Yet, in most of the world these have been the main political goals for the feminist movement in the fight to make abortion legal and safe. Other strategies have also been incorporated into these goals. But in each case, abortion remains a crime, causing pervasive and profound damage for the providers and for women, and maintaining abortion as a part of an exceptionality regime suspended in its own illegality. This article discusses such limitations. It then focuses on Colombia and the experiences of feminist collective La Mesa por la Vida y la Salud de las Mujeres, which is campaigning to have abortion removed from the criminal law. In particular, this article examines a double standard in Colombian law: while abortion has been declared a fundamental right, it remains a crime in the penal code.

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Introduction

Most countries in Latin America and the Caribbean have partially liberalized abortion, with only a few maintaining absolute bans. Abortion laws vary widely throughout the region and include the following types of restrictions:

- the most restrictive model: total criminalization (for example, El Salvador and the Dominican Republic)[1]
- the narrow indications model: countries that permit abortion to save the pregnant woman's life (for example, Paraguay and Venezuela)
- the broader indications model (for example, Colombia), and
- the time-limit model: supporting abortion until a specific gestational age, without requiring a concrete reason for termination—that is, on request (for example, Uruguay and Mexico City).

In other words, liberalization has occurred through one of two models widely described in the literature: the indications model, which permits abortion on certain legal grounds, and the time-limit model, which allows abortion until a certain stage of pregnancy, regardless of the reasons, with the most common cutoff point being 12 weeks.[2] That said, the time-limit model usually applies certain grounds in cases where the time limit has passed, and the indications model allows abortion only up to a certain gestational age. Despite these advances, national penal codes across the Latin American and Caribbean region all classify abortion as a crime, including those in jurisdictions with the most liberalized abortion laws: Uruguay, Mexico City, and Cuba. It is within this contradictory and restrictive framework that progress toward liberalizing abortion has slowly been made.

While the indications model is the most common model in the region, there was no effective access for decades to legal abortion on the specified grounds; it was legal in name but not in practice, and prior to 2000, efforts to implement those grounds were almost nonexistent.[3] From 2000 onward, feminist movements spearheaded advocacy efforts to broaden the interpretation and implementation of the grounds under which abortion could be accessed.[4] Each country's political context, feminist struggles, and legal battles between progressives (pro-abortion rights) and conservatives (anti-abortion rights) have influenced the type of regulations adopted.[5]

In 2006, Colombia's Constitutional Court issued Sentence C-355, partially decriminalizing abortion by permitting it on three specific legal grounds: 1) when a woman's pregnancy is the result of rape, non-consensual artificial insemination or transfer of a fertilized egg, or incest; 2) when the pregnant woman's physical or mental health is at risk; and 3) when the pregnancy involves fetal malformation incompatible with life. While the court ruled that these grounds all involve women's fundamental rights, it did not eliminate the crime of abortion from the penal code.[6] In various rulings since 2010, the court has emphasized that

> *the right to the voluntary termination of pregnancy is a fundamental right per se, given that it is part of so-called reproductive rights and more specifically reproductive autonomy, whose fundamental status was recognized by the court in Sentence C-355 of 2006.*[7]

Although the court has generally linked this right to the three legal grounds established in 2006—meaning that abortion in other circumstances could legally constitute a crime—Sentence T-301 of 2016 refers multiple times to "abortion's nature as a fundamental right."[8] Thus, since the court's ruling, these two legal categories—the crime of abortion and the legal right to abortion in certain circumstances— have existed alongside each other.

Since the 2006 Constitutional Court ruling, La Mesa por la Vida y la Salud de las Mujeres (La Mesa) has been working with other national nongovernmental organizations to support its implementation.[9] La Mesa is a Colombian feminist organization founded in 1998 to fight for the full decriminalization of abortion. It is composed of individual experts in health, law, and related fields, as well as organizations and other national feminist

networks, including health care providers and legal advocates.[10]

La Mesa's efforts in this regard have included the identification, classification, and documentation of barriers to access, as well as efforts to raise awareness of these barriers in order to influence abortion regulations; legal assistance for women who seek abortions and have had to confront these obstacles; and the production of expert knowledge aimed at supporting a broad interpretation of the three legal grounds, particularly the health legal ground, consistent with international human rights law.[11] Efforts by La Mesa and other social actors have resulted in the health legal ground being the principal reason recorded by health professionals for legal abortions in the two largest national hospitals providing care in this area.[12]

Nonetheless, nearly 13 years of sustained efforts to ensure the implementation of these grounds have not resulted in great advances. A recent La Mesa study shows that women in Colombia are still unable to make decisions about their bodies, due to the following facts:

1. abortion remains mainly illegal (less than 1% of all abortions are legal);
2. women continue to face many barriers when trying to access abortion through the public health system;
3. the provision of services is geographically limited and access deeply unequal;
4. committed providers are scarce and the provision of care is arbitrary; and
5. prosecutions of women have increased in spite of the legal framework and the favorable opinion of the general public of women's autonomy on abortion.[13]

The time has come for the feminist movement to propose our own rules and to use our own language in the debates.

For all these reasons, La Mesa is fighting for the crime of abortion to be eliminated from Colombia's penal code. Our analysis draws on the experiences of countries such as Canada, which eliminated the crime of abortion based on a solid critique of its previous model (the indications model) and the inequalities it was perpetuating.[14] Analysis is also situated within the framework of a broader criticism of abortion models that are based on criminalization. As Erdman and Cook note, as a result of the many dysfunctions of current laws, "the human rights consensus has moved towards the decriminalization of abortion, that is, the repeal of criminal abortion laws and generally, the removal of abortion as a legitimate subject of criminal law."[15] Next, we outline why repealing the crime of abortion should be the next step toward liberalization of abortion in Colombia.

A critique of current abortion models: Grounds and time limits

Criminalizing abortion undermines women's autonomy and citizenship and suggests that women must share their reproductive autonomy with others, usually doctors and judges. A woman can receive certain health services only if she has a certificate from a physician or a judge, or if she has complied with certain requirements that vary from country to country and which prevent her from accessing legal and safe abortion services in a timely manner.[16]

In this regard, the requirements outlined in the indications model function as restrictions that subject women's decision making to a medical referral, to service providers' interpretations of the legal framework, or to the suffering expressed through a victimizing story. Depending on how narrowly or broadly a doctor interprets the law, the doctor or the woman may or may not be considered criminal. Abortion becomes the decision of a third party who, the woman hopes, will consider the procedure her best option. This all stems from trying to "fit" abortion into one of the legal grounds, which in many cases means disregarding human rights standards.

The time-limit model is similar in that it requires third-party supervision of a woman's decision. Requirements such as mandatory waiting periods and pre-abortion and multidisciplinary counseling call a woman's judgment into question,

such as when women are forced to observe a reflection period before their decision is "accepted." Nonetheless, this model is more protective of women's autonomy—at least during the established time frame—even if it only partially recognizes women's moral capacity. Even so, it is often the case that access barriers push women to miss relevant time limits, resulting in the denial of abortion. In certain regions of Uruguay, for example, more than 80% of gynecologists exercised abortion-related conscientious objection during 2013–2017, undoubtedly leading to delays throughout the process.[17]

The existence of specific grounds and time limits is arbitrary and lacks an evidence base, and it is difficult to find good reasons why such elements should be maintained in the law.[18] Why, for example, do some countries allow abortion up to 8 weeks, while others allow it up to 12 or 14 weeks? Why is autonomy only recognized for 12 weeks, and why is it still subjected to a third party's opinion or counseling, or to a reflection period? Why do some laws, as in Colombia, allow abortion after "forced insemination," given that no such cases have ever been documented and that this does not constitute a real risk to women? Why don't these grounds instead include very young age, or the woman's social and economic constraints? The exceptions to the crime of abortion often do not correspond to the concrete needs of women or to the multiple reasons—not always disease, health, or biologic life—why women want an abortion.

Furthermore, as we will see below, using criminalization to defend life in gestation is ineffective, for, as Undurraga writes, "the fierce defence of unborn life would only be consistent if at the same time it could be shown that criminalisation of abortion results in fewer abortions."[19]

Under the indications model, doctors, administrators, and judges play a regulatory role. They are "moral entrepreneurs" who use their power to impose and normalize their personal judgments through discourse and practice—in other words, to impose their own moral views through the provision of services.[20] An example can be seen in the barriers that women face due to the denial of abortion services, such as drawn-out administrative procedures, court orders that fail to respect applicable regulations, and conscientious objection by health professionals who use this mechanism more as a way to prevent women from aborting than as a tool for respecting their own freedom of conscience. Above all, doctors, administrators, and judges use this mechanism to sidestep the stigma associated with the crime of abortion.[21] These erect an extensive scaffolding around the protection of prenatal life—which the state has enshrined—which encompasses the crime and its punishment, including prosecution and incarceration. It also leads to the provision of unsafe abortion services, the sale of overpriced medications on the black market, the provision of legal abortion services only in tertiary-level health facilities, and numerous other consequences for women, including the forced continuation of pregnancy, negative health impacts, and even risks to their lives.[22]

But in all these models, we can highlight the persistence of criminalization as the legal ground which, in the case of Colombia, clearly produces a double standard. This double standard permeates all spheres of social life and cultural imaginaries, including the provision of services, the providers, women, legislators, and politicians.

Human rights standards and the use of criminal law: An unresolved contradiction

According to the Colombian Constitutional Court, the *nasciturus* (unborn) cannot claim a legal right to life and is thus not a "subject of rights"; rather, the constitution enshrines a "protection of life" that does not carry the same level of protection as the right to life.[23] Drawing on the principle of proportionality—a tool for evaluating state actions that might affect the enjoyment of fundamental rights, as well as the content of those rights—the court has signaled that the constitutional value of life is not absolute and must be balanced against other values, principles, and constitutional rights, and it is for this reason that in Colombia the fetus does not have a right to life.[24] As the court stated in Sentence C-355:

> *If criminal punishment for abortion is based on the precondition of the supremacy of the legal right of the*

> *life in gestation over other constitutional protections at play, in this specific hypothesis there is no equivalence whatsoever between, on the one hand, the mother's rights not just to life but also to health and, on the other, the safeguarding of the embryo.*[25]

The Constitutional Court also recognized women as subjects of the right to dignity, free development of personality, and reproductive autonomy, reminding lawmakers:

> *We cannot ignore the fact that women are fully worthy human beings and should be treated as such, as opposed to being deemed mere reproductive instruments for the human race or being forced in certain cases, against their will, to serve as tools of procreation … The right to be a mother—or, in other words, the right to opt for maternity as a "life choice"—is a decision of the utmost privacy for every woman.*[26]

The court also recognized the right to health, establishing that pregnant women and girls have the right to access abortion when their pregnancy poses a risk to their life or health, the latter of which must be understood broadly to include both mental and physical health.[27]

According to Colombia's penal code, "Punishment must comply with the goals of general prevention, just retribution, special prevention, and social reintegration."[28] In other words, by classifying certain conduct as a crime and by applying punishment accordingly, the penal code should help prevent such acts from occurring, repair as far as possible the damage done to society, and "positively influence the future behavior of perpetrators of the offense"—that is, it should send a message to *criminals*, which will prevent them from committing the offense again.[29] Punishment is the tool by which offenders understand the fault in their behavior and modify their relationship with society.

If we accept this as the goal of punishment, we can see that classifying abortion as a crime is ineffective to the extent that:

1. it is not a *preventive measure*, since it does not prevent women from getting abortions, although it can be effective in telling women that committing a crime is not only bad in itself but also carries a penalty;
2. it is not a measure of *just retribution*, since criminalization violates women's fundamental rights as enshrined in the constitution; and
3. it does not promote women's *reintegration into society*, since when a woman accesses an abortion, which is recognized as a fundamental right in connection with other rights, she is neither altering the social order nor breaking any rules of civic coexistence, except that which sees maternity as the only valid form of femininity and as women's destiny (which the court rejected).

In this way, the classification of abortion as a crime embodies a utilitarian approach to punishment without achieving the objective of imparting justice while creating harmful consequences. And it becomes a tool for controlling women's reproduction. According to the literature, this model fails to recognize women's liberty and moral autonomy, for, of all liberties, women's liberty is the one most intimately connected to the physical body and to reproduction. Laws that punish abortion have the effect of placing pregnant women at odds with the fetus instead of acknowledging that "the act of conception and even [a woman's] desire for it does not imply an intention and much less a desire for maternity."[30] The issue is one of women's moral autonomy insofar as she is the one who determines the future of the fetus, namely whether it is "destined by the mother to be born."[31]

The indications model: Producing and reproducing inequalities and stigma

Colombia's progress in ensuring compliance with the grounds outlined in its abortion law—as well as its development of abortion-related jurisprudence by the Constitutional Court—has been significant compared to other countries in Latin America.[32] Nonetheless, the country's robust jurisprudence and generous policy and regulatory framework recognizing sexual and reproductive rights have failed to ensure that access to abortion services is

adequate, equal, and free of barriers.

Among the shortcomings of Colombia's current model is the failure to recognize the many reasons why a woman might decide to terminate a pregnancy. The indications model transmits the idea that some abortions are more acceptable than others—that is, that some reasons for having an abortion are more valid than others—and that all women are at the mercy of the personal interpretation of a professional who must certify that they meet the necessary legal conditions to be able to access an abortion. But women have the moral capacity and dignity to make decisions about their own bodies and to decide for themselves whether to pursue motherhood.

According to the Ministry of Health and Social Protection, 68,901 cases of treatment were recorded nationwide over the past decade (2009–2018) in relation to miscarriage and abortion, including the voluntary termination of pregnancy. According to data that La Mesa has collected from the country's local health departments, however, the actual number is far higher.[33] For example, data from the Secretariat of Health of Bogotá reveals an annual average of 9,000 abortions between 2015 and 2017, suggesting that the aforementioned national figure is greatly inaccurate.[34] Moreover, the Guttmacher Institute reports that as of 2008, the average number of abortions in Colombia each year was 400,400, and it was estimated that less than 1% of these abortions were legal.[35] While the number of legal abortions has increased in recent years, it is still nowhere near the number carried out illegally. In any event, the absence of accurate data, the fragmented manner in which it is gathered, and the low priority placed on this issue by the country's public policies reveal the stigma still surrounding the procedure.

Moreover, La Mesa has verified that abortion services are not available consistently throughout the country—they are concentrated in the largest cities—and are barely available for second- and third-trimester abortions. As a result, women who live in rural areas or far from major cities must incur out-of-pocket expenses, travel long distances, miss work, and be away from their homes and support networks as they seek safe abortion services, which translates into unjustified delays and the need for a late-stage abortion.

Due to the way the legal grounds are interpreted, the current model of decriminalization based on certain limited legal grounds leads to the provision of abortion services in public facilities that generate greater costs for the health system. There is no timely or effective access to abortion care, abortions are carried out in more complex settings than is necessary (involving expensive, outdated, and invasive techniques, along with an excessive number of specialists, such as anesthesiologists and obstetrician-gynecologists), and service provision is delayed as a way to punish women.[36]

There are also other systemic barriers to women's access to legal abortion, which violate current regulations and constitute a form of violence against women according to the Convention on the Elimination of All Forms of Discrimination Against Women. La Mesa classifies these barriers as follows:

1. lack of knowledge of the legal framework, which results in non-compliance with regulations on women's abortion-related rights, such as the right to dignity, confidentiality, and to accurate and objective information;
2. restrictive interpretations of the legal framework, including additional requirements beyond those established by the Constitutional Court, such as authorization by a medical board or third parties, as well as a narrow understanding of the meaning of health; and
3. shortcomings in health service provision, such as failings at the administrative level and among health care professionals. Thus, for example, just 50% of Colombia's departmental secretariats of health have issued guidelines that are in line with the standards established by the Constitutional Court and national regulations, which help ensure the provision of abortion services.[37]

These barriers are aggravated by the stigma, stereotypes, and prejudices surrounding abortion, which

brand it as a morally reprehensible practice and label the women who have abortions as transgressing the feminine ideal that equates femininity with maternity and as straying from the sexual and reproductive behavior that is expected of them—all of which leads to finger pointing, censure, and ill treatment of women and abortion service providers.[38]

The continued criminalization of abortion has palpable consequences for the lives of girls, adolescents, and women. According to data published by the office of Colombia's attorney general, 2,290 women were criminalized—that is, involved in criminal proceedings—for the offense of abortion in 2017.[39] The age group most commonly involved in these proceedings was 15–19 years (25.2%), followed by 20–24 years (18.8%). Among the cases reported by the attorney general's office, three involved girls aged 11 and 12, meaning that rape should have been presumed and they should have been able to access abortion on sexual violence grounds. They should also have been allowed to initiate a process for the restoration of their rights, which seeks to guarantee the rights of girls and adolescents and prevent them from suffering future violations. In terms of educational attainment, only 39.3% of those being prosecuted had completed high school and 28.6% had completed only elementary school. We can thus see that adolescents and young women with little education are the ones most commonly experiencing criminal punishment, a fact that undoubtedly exacerbates social inequalities by compounding the violation of the rights of the youngest and least-educated women.

The departments of Santander (6.6%), Tolima (6.1%), Caldas (5.9%), and Valle del Cauca (5.9%) follow Bogotá (12.8%) in the number of criminal proceedings. These departments are among those most affected by the war between the state and illegal armed groups that began in the 1960s; the armed conflict involved significant human rights violations against women, such as sexual violence and the forced rejection of traditional models of femininity. These departments also have high rates of poverty and weak public institutions.

The path to repeal the criminalization of abortion

Our call to eliminate the crime of abortion in Colombia hinges on the claim that no woman should be imprisoned or otherwise punished for having an abortion, and that no health care provider should be imprisoned or otherwise punished for providing safe abortion services at the woman's request, or for providing abortion-related information. Women in Colombia should be treated as full citizens whose life plans are guaranteed by the state—by conferring legitimacy to their lives and their biographies—and, in this way, given back the autonomy that has been taken from them through restrictive abortion laws.[40] We call this claim just cause.

Decriminalization means ceasing to treat an action as a criminal offense.[41] Specifically, decriminalizing a particular conduct removes it from the criminal sphere in such a way that it is no longer unlawful or deserving of punishment. In the case of abortion, decriminalization alone does not necessarily translate into effective access to abortion services, for even though the procedure would no longer be subject to punishment, there are other mechanisms of state control that could still be used to impede its free and legal exercise, such as restrictive measures established through other legal regimes but not part of the criminal code (time limits or legal grounds) or administrative means (health authority requirements).

But decriminalization is desirable both to decrease the rate of unsafe abortion and abortion-related morbidity and mortality and to protect women's rights. A country's legal framework and its access to abortion services are the two elements that determine abortion-related morbidity and mortality.[42] Thus, abortion is less safe in countries with more restrictive laws, which is why almost 77% of abortions in Latin America are unsafe or less safe, while a mere 23.6% are safe.[43] The harsh criminalization of abortion leads to unsafe abortions that are provided outside the health system and can have serious impacts on women's health, including death. Meanwhile, countries that have decriminalized abortion more broadly have seen

a significant reduction in (and even the absence of) serious health complications stemming from underground procedures. Put another way, criminalization does not prevent abortion, but drives it underground and causes negative health consequences for women, especially poor women and girls, who are most at risk of having to resort to unsafe illegal abortions.[44]

Thus, our just cause proposal for complete decriminalization has two distinct components: first, the removal of abortion from the penal code and from the state's use of punitive power in a broader sense, with the aim of preventing the curtailment of women's reproductive rights, normalizing the practice of abortion, and reducing stigma; and second, the subsequent legitimation of abortion services. In this way, it seeks to advance citizen empowerment for women, including those who choose not to pursue maternity.[45] Such recognition of citizenship should also involve the normalization of abortion as health care, and the possibility of women being able to choose their abortion method (including abortion pills for self-managed abortion) for personal reasons.

Colombia must move in this direction if the state is to uphold its commitment to women within the framework of the constitution and international and regional human rights instruments. In this regard, international treaties signed by Colombia (such as the Covenant on Civil and Political Rights, the Convention on the Elimination of All Forms of Discrimination Against Women, and the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women), as well as the constitution, have all outlined standards for the protection of women's sexual and reproductive rights, including abortion. These instruments have done this by acknowledging the direct relationship between the provision of this medical service and respect for women's rights to life, health, reproductive autonomy, free development of personality, to dignity and to freedom from cruel, inhuman, and degrading treatment, as well as their recognition as rights holders and equal citizens under the law.[46] Women's exercise of reproductive autonomy means being entitled to complete, accurate, and timely information; having access to health services that are respectful of their confidentiality and privacy; being able to access abortion services under safe conditions that do not incur the risk of being reported to the police by health care workers; and generally being free from the various types of humiliation, distress, suffering, and poor treatment that stem from being powerless, from clandestine abortion services, and from the moral and criminal sanctions related to restrictive legal environments.[47] Indeed, the Human Rights Committee's 2018 recommendations on the meaning of the right to life in relation to abortion state that measures designed to regulate the procedure must not result in the violation of women's right to life.[48]

Along these same lines, the final report of Colombia's Advisory Committee on Criminal Policy (2012), notes that the Constitutional Court's sentence establishing the indications model is the *minimum* standard for rights protection with regard to abortion and that its adoption does not mean that the state cannot or should not seek more vigorous decriminalization.[49]

Meanwhile, recent events around abortion in Argentina, where more than 800 experts participated in a debate on decriminalizing abortion up to 14 weeks in 2018, and in Chile, where abortion was recently liberalized under some circumstances, led to massive mobilizations among young feminist women throughout most of the Caribbean and Latin America, including Colombia.[50] These mobilizations built on March 8 protests against gender-based violence, sexual abuse, and femicide, and were supported by politicians, lawmakers, health care professionals, lawyers, and various experts. They are a clear expression of the cultural change taking place.

This cultural change is also expressed in the upsurge of a conservative counter-mobilization, both against abortion law reform and against "gender ideology," which is a campaign against equality and rights that is based on lies and fear and which has emerged largely in Latin American countries, some European ones, and the USA.[51] Colombia has been no stranger to this campaign, which revealed the extent of its reach when it managed to

connect the country's peace agreement—signed in 2016 between the Santos administration and the Revolutionary Armed Forces of Colombia—to the supposed erosion of family values and transformation of traditional gender roles (including recognition of the right to abortion).

Nonetheless, and despite these attacks, public opinion in Colombia has changed for the better with regard to abortion. This shift is evidenced in the results of the first Encuesta de Percepción sobre Interrupción Voluntaria del Embarazo, carried out in 2017 by La Mesa with the assistance of the polling company Cifras y Conceptos.[52] The survey was representative and polled 2,277 people in 31 capital cities of Colombia (44% of respondents were women aged 18–44 and 56% were men aged 18–55). The questions addressed sexual and reproductive life, the decriminalization of abortion, the grounds for decriminalization, unsafe abortion, the right to information, and the role of the women's movement and presidential candidates.

The survey's results reveal a favorable public perception of women's reproductive autonomy and a general rejection of criminalization. When asked about who should be able to influence a woman's decision to terminate a pregnancy, 62% of respondents answered "no one," believing that it was the woman's decision alone; and 47% believed that it should be a free decision of the woman. In response to the question "How much do you agree or disagree with the idea that women who have abortions should go to jail?" 61% of respondents indicated disagreement—in other words, the majority of the Colombian public rejects criminalization of women who have abortions. Furthermore, 40% of respondents said that it was important for their presidential candidate to defend the right to abortion, repositioning safe, legal abortion as politically important and connected to women's citizenship.

Conclusion

At its core, the indications model embraces a set of restrictive rules that reflect the lesser legitimacy afforded to women's lives within contemporary politics when it comes to abortion—that is, when women decide not to continue a pregnancy.[53] As a regulatory model, it places a greater value on prenatal life (biological life), thereby upholding the need for the crime of abortion. This superior status awarded to the fetus's biological life circumscribes the very essence of the protection of women's lives, which are both biological and biographical.[54] For one, the legal grounds are associated with biological conditions, such as a risk to the pregnant woman's health or life and/or the presence of a fetal malformation or anomaly. Second, this centrality of fetal life devalues women's lives, dispossessing them of their liberty and, in turn, their enjoyment of other rights, including social, cultural, and political ones.

As Didier Fassin argues, we are facing an era in which the recognition of the right to life is intertwined with the biological dimension of the legitimacy afforded to it.[55] This notion of "life itself," he says, pushes out biographical life and, with it, aspirations for justice. He writes

> *I have proposed the term "biolegitimacy" for this recognition of life as the highest of all values—life that must be understood in the sense of being alive … among all the possible meanings we could ascribe to the human condition, the one we have placed at the summit of our system of values is that which relates the most restricted but also the most unarguable definition of life...*[56]

Biolegitimacy thus offers an innovative alternative in the struggle to liberalize abortion by placing women's lives front and center—not just their biological lives but also their biographical lives—recognizing all types of life plans, suffering, and health needs that this particular reproductive event implies, and providing to women for the first time the autonomy that has been snatched away by criminal laws.

Therefore, the total decriminalization of abortion, elimination of the crime, and regulations to secure care provision would attain women's biolegitimacy for the first time in the debate on abortion: it would make their lives valuable as biography and as biology —in a comprehensive way. Without the

crime of abortion, without the legal grounds, without the stigma, without legal coercion or regulation, and with the normalization of abortion care as a regular health service, we can begin to transform the terms of the debate and to conquer our right to abortion and, by extension, our right to full gender equality.

References

1. "Doctors, surgeons, midwives, nurses and pharmacists, who, based on their profession, practice abortion or cooperate with it, will be subject to 5 to 20 years of public work when abortion actually happens." Police Code, Dominican Republic, art. 317, 2014. For more information, see https://abortion-policies.srhr.org/country/dominican-republic/; https://reproductiverights.org/worldabortionlaws?country=DOM.

2. J. N. Erdman and R. J. Cook, "Decriminalization of abortion: A human rights imperative," *Best Practice and Research: Clinical Obstetrics and Gynaecology* (2019). Available at https://doi.org/10.1016/j.bpobgyn.2019.05.004.

3. A. C. González Vélez (Coord.), *Las causales de la ley y la causa de las mujeres. La implementación del aborto legal en Colombia: diez años profundizando la democracia* (Bogotá: La Mesa por la Vida y la Salud de las Mujeres, 2016).

4. A. C. González Vélez, "Una mirada analítica a la legislación sobre interrupción del embarazo en países de Iberoamérica y el Caribe," *Serie Mujer y Desarrollo de la CEPAL* (2011).

5. S. Gloppen, C. Gianella, M. Langford, et al., *Sexual and Reproductive Rights Lawfare* (2014). Available at https://www.cmi.no/projects/1836-sexual-and-reproductive-rights-lawfare.

6. See Código Penal Colombiano, Ley 95 de 1936; Código Penal Colombiano, Ley 100 de 1980; Código Penal Colombiano, Ley 599 de 2000; Constitutional Court of Colombia, *Sentencia C-355/06* (May 2006). Available at http://www.corteconstitucional.gov.co/relatoria/2006/C-355-06.htm.

7. Constitutional Court of Colombia, *Sentencia T-841/11* (Nov 2011). Available at http://www.corteconstitucional.gov.co/RELATORIA/2011/T-841-11.htm.

8. In this regard, see Constitutional Court decisions T-585 de 2010; T-841 de 2011; T-627 de 2012; C-754 de 2015; T-301 de 2016; SU-096 de 2018.

9. Constitutional Court of Colombia, *Sentencia T-301/16* (June 2016).

10. For more information about La Mesa, see www.despenalizaciondelaborto.org.co. For more in-depth treatment of these issues in Spanish, see La Mesa. La Mesa por la Vida y la Salud de las Mujeres, *La despenalización del aborto en Colombia: Una causa justa* (Bogotá, forthcoming, 2019); and A. C. González-Vélez's unpublished PhD thesis, La economía moral de las normas restrictivas sobre aborto en América Latina: Vidas ilegítimas o de cuando la propia norma es la violación. Peter Lang Publishing, forthcoming.

11. A. C. González Vélez and I. C. Jaramillo, "Legal knowledge as a tool for social change: La Mesa por la Vida y la Salud de las Mujeres as an expert on Colombian abortion law," *Health and Human Rights Journal* 19/1 (2017), pp. 109-118.

12. A. C. González Vélez, "The health exception: a mean for expanding access to legal abortion," *Reproductive Health Matters* 20/40 (2012), pp.1-8.

13. La Mesa por la Vida y la Salud de las Mujeres (see note 10).

14. W. D. Thomas, "The Badgley report on the abortion law," *Canadian Medical Association Journal* 116/9 (1977), p. 966. Available at https://www.ncbi.nlm.nih.gov/pubmed/858113.

15. Erdman and Cook (see note 2).

16. P. Deutscher, "The inversion of exceptionality: Foucault, Agamben, and 'Reproductive Rights'," *South Atlantic Quarterly* 107/1 (2008), pp. 55-70. Available at https://read.dukeupress.edu/south-atlantic-quarterly/article-abstract/107/1/55/52619/The-Inversion-of-Exceptionality-Foucault-Agamben; González Vélez (2018, see note 10).

17. MYSU, *Estado de situación de los servicios de salud sexual y reproductiva y aborto legal en 10 de los 19 departamentos del país. Sistematización de resultados Estudios Observatorio MYSU 2013-2017* (Montevideo: MYSU, 2017). Available at https://issuu.com/mujerysaludenuruguay/docs/informe_observatorio_2017_10de19_we.

18. J. N. Erdman, "Theorizing time in abortion law and human rights," *Health and Human Rights Journal* 19/1 (June 2017), pp. 29-40.

19. V. Undurraga, "Criminalisation under scrutiny: How constitutional courts are changing their narrative by using public health evidence in abortion cases," *Sexual and Reproductive Health Matters* 27/1 (2019).

20. D. Fassin, *When bodies remember: experiences and politics of AIDS in South Africa* (Berkeley: University of California Press, 2007).

21. A. C. González Vélez, "Conscientious objection, bioethics and human rights: a Colombia perspective," *Bioethics and Law Journal* 42 (February 2018), pp. 105-126. Available at http://revistes.ub.edu/index.php/RBD/article/view/18590/23326.

22. González Vélez (2018, see note 10).

23. Constitutional Court of Colombia, *Sentencia T-327/16* (June 2016). Available at http://www.corteconstitucional.gov.co/RELATORIA/2016/C-327-16.htm.

24. See Constitutional Court of Colombia, *Sentencia T-627/12* (August 2012). Available at http://www.corteconstitucional.gov.co/relatoria/2012/t-627-12.htm.

25. Constitutional Court of Colombia (2006, see note 6).

26. Ibid.

27. Ibid.

28. See Colombian Penal Code, 2000. Available at http://www.secretariasenado.gov.co/senado/basedoc/ley_0599_2000.html.

29. T. Hörnle, *Teorías de la pena* (Bogotá: Universidad Externado de Colombia, 2011), p. 26.

30. T. Pitch, *Un derecho para dos: la construcción jurídica de género, sexo y sexualidad* (Madrid: Trotta, 2003), pp.13-14; p.83.

31. L. Ferrajoli, "La cuestión del embrión entre derecho y moral," *Jueces para la democracia. Información y debate* 44 (July 2002), pp. 3-12. Available at https://dialnet.unirioja.es/servlet/articulo?codigo=264121.

32. See, for example, Corte Constitucional, C-355 de 2006, T-988 de 2007, T- 209 de 2008, T-946 de 2008, T-009 de 2009, T-388 de 2009, T-585 de 2010, T-636 de 2011, T- 841 de 2011, T-532 de 2014, C-754 de 2015, T-301 de 2016, T-697, T-731 de 2016, and SU-096 de 2018.

33. Ministerio de Salud y Protección Social, public hearing on women prosecuted for abortion (Bogotá, October 4, 2018).

34. Secretaría Distrital de Salud de Bogotá, file no. SDS 2017ER30407 (May 18, 2017), response to an information request from the Concejo de Bogotá.

35. Guttmacher Institute, *Embarazo no deseado y aborto inducido en Colombia: causas y consecuencias* (2011). Available at https://www.guttmacher.org/sites/default/files/report_pdf/embarazo-no-deseado-colombia_1.pdf.

36. E. Prada, I. Maddow-Zimet, and F. Juarez, "The cost of postabortion care and legal abortion in Colombia," *International Perspectives on Sexual and Reproductive Health* 39/3 (September 2013), pp. 114-123.

37. A.C. González Vélez and L. Castro, *Barreras de acceso a la Interrupción Voluntaria del Embarazo en Colombia* (Bogotá: La Mesa por la Vida y la Salud de las Mujeres, 2017).

38. K. Cockrill, S. Herold, K. Blanchard, et al., *Addressing abortion stigma through service delivery: A white paper* (Sea Change Program, Ibis Reproductive Health, and ANSIRH, 2013). Available at https://ibisreproductivehealth.org/sites/default/files/files/publications/Addressing%20abortion%20stigma%20through%20service%20delivery.pdf.

39. Delegada para la Seguridad Ciudadana de la Fiscalía General de la Nación, file no. 20176111013202 (October 23, 2017), response to an information request submitted by La Mesa por la Vida y la Salud de las Mujeres.

40. González Vélez (2018, see note 10).

41. R. Guillien and J. Vincent, *Diccionario jurídico*, 2nd ed. (Bogotá: Temis, 2015), p. 149.

42. *Guttmacher Institute, Aborto a nivel mundial 2017: Progreso irregular y acceso desigual. Available at* https://www.guttmacher.org/es/report/aborto-a-nivel-mundial-2017-resumen-ejecutivo.

43. R. Schiavoni, "Aborto: un problema de salud pública y de derechos humanos, *c. l. Aportaciones al debate. Reunión informativa*. Buenos Aires, Argentina (2018).

44. Comisión Asesora de Política Criminal, *Informe final. Diagnóstico y propuestas de lineamientos de política criminal para el Estado colombiano* (Bogotá, 2012), p. 75. Available at https://www.minjusticia.gov.co/Portals/o/INFO%20POLI%20CRIMINAL_FINAL23NOV.pdf.

45. González Vélez (2018, see note 10).

46. *Hard law* (International Covenant on Civil and Political Rights, 1966; International Covenant on Economic, Social and Cultural Rights, 1966; Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1984; Convention on the Elimination of All Forms of Discrimination against Women, 1979; Convention on the Rights of the Child, 1989; American Convention on Human Rights; Convention of Belém do Pará, 1994). S*oft law* (International Conference on Population and Development, Cairo, 1994; Regional Conference on Population and Development in Latin America and the Caribbean (Montevideo Consensus), 2013; Fourth World Conference on Women, Beijing, 1995; Millennium Development Goals, 2000; Sustainable Development Goals, 2015).

47. Regarding complete, accurate, and timely information on abortion, see P. Bergallo and A. C. González Vélez, *Interrupción legal del embarazo por la causal violación: Enfoques de salud y jurídico* (Bogotá: La Mesa por la Vida y la Salud de las Mujeres, 2012), p. 58. Regarding optimal health services, see *Artavia Murillo y otros (Fertilización in vitro) v. Costa Rica* (Inter-American Court of Human Rights, Case No. 12,361). Regarding access to safe abortion, see *Caso LC v. Perú* (CEDAW Committee, UN Doc. C/50/D/22/2009); L. I. Meléndez López, "Hablemos de embarazos forzados y violencia sexual," *Derecho and Sociedad* 47 (2016), pp. 243-257. Available at http://revistas.pucp.edu.pe/index.php/derechoysociedad/article/view/18888.

48. UN Human Rights Committee, General Comment No. 36 (2018) on article 6 of the International Covenant on Civil and Political Rights, on the Right to Life, UN Doc. CCPR/C/CG/36 (2018), para. 8.

49. Comisión Asesora de Política Criminal (see note 44).

50. See REDAAS, *De la clandestinidad al Congreso: Un análisis del debate legislativo sobre la Ley de Interrupción Voluntaria del Embarazo en Argentina* (2019). Available at http://repositorio.cedes.org/handle/123456789/4514; República de Chile, *Ley 21030: Regula la despenalización de la interrupción voluntaria del embarazo en tres causales* (2017). Available at https://www.leychile.cl/Navegar?idNorma=1108237.

51. A. Wilkinson, "Latin America's gender ideology explosion," *Anthropology News* 58 (March 21, 2017). Available at https://doi.org/10.1111/AN.379.

52. Survey on Perceptions of Voluntary Interruption of Pregnancy in Colombia. For more information on the survey, see https://bit.ly/2N8ilKZ.

53. . González Vélez (2018, see note 10).

54. P. Laurenzo Copello, *Dogmática y política criminal del aborto* (Valencia: Tirant Lo Blanch, 2012).

55. See D. Fassin, "Gobernar por los cuerpos, políticas de reconocimiento hacia los pobres y los inmigrantes en Francia," *Cuad. antropol. soc.* 17/1 (2003), p. 49-78. Available at http://www.scielo.org.ar/scielo.php?script=sci_arttext&pid=S1850-275X2003000100004; Fassin (2007, see note 20); D. Fassin, "Humanitarianism as a politics of life," *Public Culture* 19/3 (2007), pp. 499-520. Available at https://www.sss.ias.edu/files/pdfs/Fassin/Humanitarianism-as-politics-life.pdf; D. Fassin, "Another politics of life is possible," *Theory, Culture and Society* 26/5 (2009), pp. 44-60. Available at http://journals.sagepub.com/doi/abs/10.1177/0263276409106349; D. Fassin "El irresistible ascenso del derecho a la vida: razón humanitaria y justicia social," *Revista de Antropología Social* 19 (2010), pp. 191-204. Available at http://revistas.ucm.es/index.php/RASO/article/view/RASO1010110191A; D. Fassin, *Humanitarian reason: a moral history of the present* (Berkeley: University of California Press, 2012). For more on the issue of biolegitimacy as it relates to abortion, see González Vélez (2018, see note 10).

56. D. Fassin (2012, see note 55), p. 249.

The Role of Reproductive Justice Movements in Challenging South Korea's Abortion Ban

SUNHYE KIM, NA YOUNG, AND YURIM LEE

Abstract

This paper examines how issues related to abortion have historically been influenced by population control policies in South Korea and how the contemporary reproductive justice movement in South Korea has contributed to social change. On April 11, 2019, South Korea's Constitutional Court ruled that the ban on abortion was unconstitutional. As a result, South Korea's legislature must revise the 66-year-old anti-abortion law by December 31, 2020. This historic decision was closely related to the advocacy of a number of feminist groups, doctors' organizations, disability rights groups, youth activists, and religious groups in South Korea, who collectively formed the Joint Action for Reproductive Justice (Joint Action) in 2017. This paper describes the activism and actions of Joint Action as a key part of reproductive justice movements in Korea. Joint Action was initiated by an organization for women with disabilities, and once formed, they worked collectively to frame abortion as a social justice issue that goes beyond the pro-choice versus pro-life binary. By focusing on the composition, strategies, and main agenda of Joint Action, this paper analyzes how Joint Action influenced the Constitutional Court's 2019 decision to decriminalize abortion in South Korea and how the court established that it is the government's responsibility to ensure every individual's reproductive health and rights.

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Introduction

On April 11, 2019, South Korea's Constitutional Court ruled that the ban on abortion was unconstitutional. As a result, South Korea's legislature must revise its 66-year-old anti-abortion law by December 31, 2020. This historic decision was made possible in response to the advocacy of a number of feminist groups, doctors' organizations, disability rights groups, youth activists, and religious groups in South Korea, who collectively formed the Joint Action for Reproductive Justice in 2017.[1] Although the goal of Joint Action was to change the law that threatened women's health and lives through the criminalization of abortion, one of the main goals of Joint Action was to challenge the very framework of pro-choice versus pro-life. Moreover, Joint Action also emphasized that more than protecting a woman's right to freely choose whether to have or not have a baby, the government has a responsibility to promote Koreans' sexual and reproductive health and rights as a social justice matter.

South Korea has a restrictive abortion law.[2] Although Korean women's rights movements have previously achieved important social changes, such as revisions in family law (2005), legislation for gender equity (1999), and anti-sexual violence laws (1994), until 2010, the abortion issue was not considered an urgent item on the feminist agenda. This was because the country's 1953 law that criminalized abortion went largely unenforced from the 1960s until the mid-2000s.[3] Under the strong anti-natalist policies implemented by the government from the 1960s to the 1980s, abortion, contraception, and sterilization were widely encouraged to reduce the nation's total fertility rate and, in some cases, were even used coercively among certain populations, including women with disabilities.[4] During this period, the South Korean government established family planning clinics nationwide that provided abortion services under the name of menstrual regulation, and the government offered strong incentives such as public housing and health insurance benefits to families who had less than two children.[5] Since abortion was widely accessible (although it was de jure illegal) until recently, mainstream feminist movements in South Korea have not focused on abortion rights. However, even though abortion was accessible, there were still problems related to the actual practices of abortion, which deeply reinforced the stratified reproduction system.[6] For example, people with disabilities, single mothers, and poor mothers were often subjected to forced abortions. Moreover, the social stigma attached to abortion was still strong. Thus, while many Korean women had abortions during their lives, it was rarely discussed in public.[7]

However, abortion finally emerged as a social agenda item after the mid-2000s, when the government began to enforce the abortion ban. Due to South Korea's criminal codes on abortion (Articles 269 and 270), many women who have wanted to terminate their pregnancies have suffered from the social stigma attached to illegal abortions as well as health risks from unsafe abortions. In this circumstance, two Constitutional Court decisions regarding the criminal codes on abortion were made in 2012 and 2019. While in 2012 the Constitutional Court decided that the existing criminal codes were constitutional, the decision was reversed in 2019, and Joint Action played a central role in this shift. In the history of the Korean women's rights movement, their efforts to legalize abortion represented the first mass movement in South Korea that foregrounded women's reproductive rights and health issues, including abortion rights. In addition, as the issue of abortion was rarely discussed among the general public in South Korea due to the strong stigma attached to unmarried women's sexual behaviors and activities, this paper will argue that the Constitutional Court's ruling that the abortion ban was unconstitutional could not have occurred without the efforts of the reproductive justice movement. Thus, it is important to examine how the reproductive justice movement made issues of sexuality and reproduction part of Korea's public and political agendas, ultimately achieving legal change in South Korea. By focusing on the composition, strategies, and main agenda of Joint Action, this paper examines the new discourses and directions for the reproductive justice movement in South Korea that were created by Joint Action.

A brief history of abortion in South Korea

Population control and abortion (1960s–2005)

Since 1953, the Criminal Act (Articles 269 and 270) has strictly prohibited abortion on any grounds. Despite this, from the 1960s to the 1980s, the major goal of South Korea's population policies was to reduce the total fertility rate so that the country could receive international aid for economic development.[8] Under the anti-natalist policies of this era, abortion was widely practiced and recommended by the government. Many women could easily access abortion and sterilization procedures at family planning clinics. As a result, South Korea's Family Planning Program was evaluated as the most successful example of a population control project as the country's total fertility rate, which was 6.0 in the 1960s, declined to 4.5 in the 1970s, then to 2.8 in the 1980s, and then dropped further to 1.6 in the 1990s.[9] In South Korea from 1989 to 2009, the number of abortions was estimated to range from 30 million to 50 million annually; however, during this time, an average of 5.6 abortion cases were prosecuted annually, which indicates the government's limited enforcement of the anti-abortion law.[10] Yet, although the abortion restrictions were not typically enforced in South Korea during this time, women still experienced barriers to accessing abortion. For instance, women seeking abortions had to get permission from their male partners, and because it was technically illegal, they could not always access the best health care services and information related to abortion.

The criminalization of abortion (2005–2012)

South Korea's population policies shifted dramatically after the total Korean fertility rate dropped to 1.08 in 2005, which at that time was the lowest rate in the world.[11] In 2005, to boost this rate, the South Korean government passed the Framework Act on Low Birth Rate in an Aging Society, revived the enforcement of the criminal codes on abortion, and set up *The master plan for the prevention of illegal abortion*.[12] Furthermore, Minister of Health and Welfare Jae Hee Chun acknowledged that the government was establishing abortion prevention policies to stimulate population growth, explaining that halving the abortion rate would significantly increase the country's total birth rate.[13] In this changed political terrain, the Pro-Life Doctors' Association was formed in 2009, and their first political act was to report obstetrics and gynecology clinics that performed abortions to the police. The unprecedented anti-abortion campaign had a direct impact on women. During this period, women who had unwanted pregnancies often went to other countries to have abortions because they could not find doctors in South Korea who were willing to risk being prosecuted. In response to the anti-abortion campaigns in South Korea, the Network for Women's Right to Decide Pregnancy and Delivery was organized in 2010, which was comprised of feminist organizations, social justice organizations, workers' unions, and other progressive groups.[14] Although the network was the first collective voice to challenge the existing criminal codes on abortion, they failed to shift the false dichotomy of pro-choice versus pro-life that dominated the Pro-Life Doctors Association's narratives. In addition, one of the controversial agenda items of the network was to expand the grounds for legal abortion listed in Article 14 of the Mother and Child Health Act to include socioeconomic reasons (Article 14 includes exceptions to the ban on abortion for cases of rape and incest, as well as for eugenic reasons).[15] However, the network was unable to reach an agreement about this agenda item; by including socioeconomic reasons among the legal grounds for abortion in the Mother and Child Health Act without challenging the criminal code, opponents argued, it could reinforce existing prejudices in Korea, including that women with disabilities and poor women should not have children.

In the meantime, the first Constitutional Court review regarding the criminal law on abortion occurred in 2010, when a midwife was charged with performing an abortion and appealed to the Constitutional Court for a review of the abortion ban. In 2012, the Constitutional Court decided the ban was constitutional. The court's decision noted that "the fetus's right to life is in the public interest" while "a woman's right to choose abortion is in an

individual's interest," concluding that, thus, "women's rights cannot be more important than the fetus's rights."[16] Following this decision, a teenage girl died during a complicated abortion procedure in November 2012. When the abortion procedure did not go smoothly, instead of transferring the patient to the hospital—which could have potentially saved her life—the doctor did not do so because he was afraid of being prosecuted for engaging in an illegal abortion procedure.[17] As a result, the doctor was sentenced to one year in jail for engaging in the abortion procedure.[18] Although this case showed how the abortion ban threatened women's lives, the government and pro-life organizations in Korea highlighted this case as showing the dangers of abortion procedures, and the network did not produce any counterarguments that gained social or political traction.

The contemporary movement to decriminalize abortion (2016–2019)

After the Constitutional Court's decision to uphold South Korea's abortion ban in 2012, the Network for Women's Rights to Decide Pregnancy and Delivery became inactive because activists involved in the network could not find ways to make significant progress in the situation. However, three years later, in 2015, the abortion issue re-emerged in feminist circles. The organization Women with Disabilities Empathy initiated the Planning Group to Make a New Paradigm for Reproductive Rights for Women with Disabilities.[19] They reviewed the history of, discourses on, and contexts of the criminalization of abortion in South Korea, and they gathered stories of abortion experiences from women with disabilities. While engaging in these activities, they realized that achieving abortion rights alone could not guarantee women's reproductive rights in South Korea without first acknowledging and addressing the forced sterilizations and abortions experienced by women with disabilities.

Recognizing this, when they began organizing for the decriminalization of abortion again, the Planning Group activists realized they needed to build their coalition using a reproductive justice framework. Reproductive justice discourses have largely grown out of the experiences of women of color in Western countries.[20] In particular, in the United States, reproductive justice discourses grew out of a recognition of the history of forced sterilization among Native Americans, African Americans, Puerto Rican Americans, women on welfare, and other marginalized populations.[21] In the South Korean context, women with disabilities have historically been the main target of forced sterilization. As such, while race and ethnicity have not been central issues in reproductive rights discourses in Korea, because of Women with Disabilities Empathy's efforts, reproductive justice issues for women with disabilities became an important agenda item.

To expand their efforts to achieve reproductive health and rights in South Korea, the Planning Group to Make a New Paradigm for Reproductive Rights for Women with Disabilities was reorganized in 2016 and renamed the Sexual and Reproductive Rights Forum (the Forum), which was comprised of Women with Disabilities Empathy, Network for Glocal Activism (NGA), the Center for Health and Social Change, Korean Lawyers for Public Interest and Human Rights, and individual researchers.[22] The Sexual and Reproductive Rights Forum became an important working group that produced new discourses and paradigms for the reproductive rights movement by revealing that the South Korean government historically had not protected the rights of pregnant women or the lives of fetuses. In addition, they held several events and published newspaper articles, opinions, and a book related to current abortion issues. Throughout these works, the Sexual and Reproductive Rights Forum argued that the 2012 challenge to Korea's anti-abortion laws had failed because the abortion issue was framed as a woman's choice versus a potential human life; they noted that if this framework was not shifted, even if they filed the case again, it would be difficult to overturn. Thus, they established a new framework for their argument: the government versus women. The main argument of the Forum was that the government historically controlled women's bodies and reproductive capacities to reduce or increase

fertility rates, thus neither supporting women's choice nor protecting human life.

Meanwhile, mass protests were triggered in September 2016 by the Korean Ministry of Health and Welfare's announcement of an amendment to the Medical Service Act that defined surgical abortion as an "unethical" medical practice and strengthened the punishment for doctors who aided in ending pregnancies.[23] These governmental efforts to further criminalize abortion and abortion providers fueled public outrage, which led to the first mass protest to demand the decriminalization of abortion in South Korea.[24] The first rally was held in Seoul on October 15, 2016. Two days later, the Forum held a press conference with other women's rights organizations and social justice groups.[25] The Forum shouted slogans during this press conference such as "the real problem is the criminalization of abortion" and "if abortion is a crime, the criminal is the state." Through their statements at the press conference, members of the Forum indicated that the government had a responsibility to rectify existing reproductive injustices and to protect everyone's sexual and reproductive rights, including the right to terminate a pregnancy or to have a child regardless of marital status, sexual orientation, ability, and socioeconomic status. Following that first mass protest, several rallies occurred around the country, many of them mobilized on social media.[26] In the same time period, Poland had a mass protest, called the "Black Protest," at which protestors spoke out against the anti-abortion law proposed by the Polish government. Images of the Black Protest circulated among Koreans via social media, and when the Forum and other feminist groups held their first rally after the pre-announcement of the revised regulations of the Medical Act, they named it "Black Protest Korea."

As the abolition of the criminal codes on abortion became an urgent item on the feminist agenda in South Korea, the Forum proposed a new solidarity group, the Joint Action for Reproductive Justice, for full-scale activism. When Joint Action for Reproductive Justice was launched in 2017, it was comprised of the Center for Health and Social Change, Femidangdang, Femimonsters, Flaming Feminist Action, Korea Sexual Violence Relief Center, Korean Women's Association United, Korea Women's Hotline, Network for Glocal Activism, Sexual and Reproductive Rights Forum, Women with Disabilities Empathy, and Womenlink. On September 28, 2017, at the International Safe Abortion Day events, the Joint Action for Reproductive Justice was officially launched.[27] Since the hegemonic discourse around abortion in South Korea had previously focused on young, heterosexual, cisgender, able-bodied women, Joint Action wanted to invite a broad range of individuals to be part of the inaugural ceremony, and thus, many different stories related to abortion and childbirth were shared by a diverse group of women, including girls, women living with HIV/AIDS, women with disabilities, queer and transgender women, and sex workers.[28] Additionally, they aimed to reveal the historical contexts and intersectionality of abortion issues, and in doing so, they intended to clearly establish the decriminalization of abortion as a matter of social justice rather than just a narrow concept of reproductive freedom. This desire to expand the discourse also drew Joint Action to recruit a wide range of progressive and social justice organizations to collaborate on the issue of reproductive rights in South Korea. For example, while only the Women's Committee in the Korean Confederation of Trade Unions was involved in the Network for Women's Right to Decide Pregnancy and Delivery in 2012, the Korean Confederation of Trade Unions became a member of Joint Action in 2017 with Joint Action's emphasis on the social injustices surrounding abortion because they agreed that abortion was not separate from labor rights issues. As of July 2019, the following organizations have also joined Joint Action: the Association of Korea Doctors for Health Rights, E-LOOM Action for Anti-Prostitution and Human Rights, Green Party Korea, Korean Confederation of Trade Unions, Korean Labor Party, Korean Women's Environmental Network, People's Solidarity for Social Progress, Sarangbang Group for Human Rights, Socialist Revolutionary Workers' Party, Student March, Tacteennaeil (ECPAT Korea), and the Association of Physicians for Humanism. By bringing all major

progressive organizations in South Korea together, Joint Action tried to build a shared direction for reproductive justice in South Korea.

Soon after its launch in 2017, Joint Action became a full-fledged coalition and sought to abolish the criminal codes on abortion as the first step to achieving reproductive justice in South Korea. They had two main strategies: 1) filing a constitutional appeal to decriminalize abortion and 2) building a public consensus to support reproductive rights. In contrast to the sociopolitical environment of 2012, they believed that they could make progress at this time because public opinion was more favorable toward abortion rights. Moon Jae-in, a member of the Democratic Party of Korea, was elected president in 2017 after the impeachment of Park Geun-hye, and in September 2017, an anonymous citizen posted a national petition for decriminalizing abortion to the administration's online national petition system. The petition received more than 230,000 signatures from Korean citizens who believed that the ban on abortion should be repealed.[29] As only a few of the roughly 1,000 petitions posted every day ever received more than 200,000 signatures, this reflected the general public's opinion against the current criminal codes on abortion.

The attorneys who were members of Joint Action formed a defense counsel for the Constitutional Court lawsuit. Initially, the constitutional appeal was filed in 2017 by a medical doctor who was prosecuted for performing an abortion, and the case focused on the criminal code regulating abortions conducted by doctors (Article 270). The attorneys and activists of Joint Action contacted the doctor and reached an agreement to proceed with the case as a public interest lawsuit, thus shifting the central issue to the criminal code on abortion (Article 269).[30] The public hearing for the case was scheduled for May 24, 2018.[31] The defense counsel wrote a 171-page pleading paper for the public hearing, and during the research and writing process, members of Joint Action played an active role by working together and sharing different groups of women's experiences to be reflected in the paper.[32]

At the same time, Joint Action lobbied the parties, government ministries, and activist groups to submit amicus briefs to the Constitutional Court. As a result, the Ministry of Gender Equality and Family, National Human Rights Commission of Korea, and Green Party Korea submitted amicus briefs stating that the government should change the current criminal codes on abortion to protect women's rights, including the right to abortion.[33] This was a big change from the 2012 Constitutional Court review because even the Ministry of Gender Equality and Family did not state any opinion publicly at that time although the Ministry of Health and Welfare announced it had no legal opinion about the Constitutional Court review. In addition, Human Rights Watch sent an amicus brief detailing how anti-abortion laws violate people's lives based on international human rights norms and standards. The UN Working Group on the issue of all forms of discrimination against women in law and in practice (WGDAW) and Global Doctors for Choice (GDC) also delivered amicus briefs to the Constitutional Court.

To bring public attention to the case and build a public consensus to abolish criminal codes on abortion, during the Constitutional Court's review of the case, Joint Action organized large rallies, an ongoing one-person demonstration in front of the court building, a signature campaign, and open forums; in addition, they participated in several TV debates.[34] Since public opinion about a law could indirectly influence the Constitutional Court's decision, Joint Action tried to keep public attention on the issue. As part of these efforts, Joint Action invited Rebecca Gomperts, founder and director of Women on Web, an organization that provides access to self-managed abortions through telemedicine, to speak at a forum in the National Assembly of South Korea in July 2018 while Joint Action advocated for the implementation of policies for safe medical abortion using abortion pills.[35] Following the event, Joint Action held a large national rally in Gwanghwamun Square in Seoul to protest the abortion ban, and approximately 5,000 protesters and 77 activist groups were present.[36] Soon after, on August 8, 2018, Joint Action held a press conference in front of the Argentine Embassy to support #ABORTO_LEGAL, an Argentina-based cam-

paign advocating for the legalization of abortion in Argentina. Along with these more traditional activities, Joint Action also engaged in non-traditional actions to share their message and garner national and international support to commemorate International Safe Abortion Day 2018.[37]

In the meantime, while the government's response to abolishing the criminal law on abortion was still lukewarm, President Moon Jae-in's democratic administration was expected to respond more favorably to the issue than the conservative President Lee Myung-bak's administration had in 2012. Although the government announced they would not accept the United Nations Human Rights Council's recommendation regarding the abolition of the criminalization of abortion, the changing political environment was favorable to the abortion rights movement during the Universal Periodic Review in March 2018.[38] As demonstrations by Joint Action continued, the National Assembly confirmed three new Constitutional Court justice nominees in October 2018. With these new nominees, which would replace term-expired justices, the Constitutional Court met the necessary preconditions for ruling on a constitutional decision (in the South Korean legal system, a nine-justice panel is required to rule in a constitutional lawsuit). Since the new nominees were considered progressive, many people anticipated that they would rule that the criminal codes on abortion were unconstitutional.[39]

As the day of the court ruling approached, Joint Action held a large protest in March 2019 to publicize their demands that the government 1) fully legalize abortion for the safe termination of pregnancy, 2) expand comprehensive sex education and access to contraceptives, 3) completely revise the eugenic elements of the Mother and Child Health Act, and 4) guarantee reproductive rights without stigma or discrimination.[40] Finally, on April 11, 2019, the Constitutional Court ruled that the current abortion ban was unconstitutional. Multiple factors led to the overturning of the 2012 Constitutional Court decision, such as a changing political environment, shifts in the general public's opinion, the progressive inclinations of judges, and a decrease in religious groups' influence on abortion in Korea. Joint Action had a pivotal role in propelling some of these changes by organizing people, sharing information, and persuading politicians to work toward reproductive justice in South Korea.

The implications of the Constitutional Court's decision on South Korea's abortion ban

On April 11, 2019, South Korea's Constitutional

Table 1. History of abortion regulations in South Korea

Year	Laws/policies/events	Brief description
1953	Criminal Act (Chapter 27, The Crimes of Abortion)	According to Articles 269 and 270, women who have abortions and medical professionals who perform abortions can be sentenced to up to two years of prison.
1961–1996	Family Planning Program	This program aimed to reduce South Korea's total fertility rate to develop the national economy, and through this program, the government encouraged women to engage in sterilization and abortion procedures.
1973	Mother and Child Health Act (Article 14, Limited Permission for Induced Abortion Operations)	This act was enacted to support the Family Planning Program. By providing limited permission for abortion in cases of rape, incest, and eugenic diseases, it functioned to justify the Family Planning Program.
2005	Framework Act on Low Birth Rate in an Aging Society	The passage of this act marked the government's policy shift from an anti-natalist policy to a pro-natalist policy.
2005	Master Plan for the Prevention of Illegal Abortion	The Plan was established by amending the Mother and Child Health Act.
2012	Constitutional Court Decision on Articles 260 and 270	The Constitutional Court ruled that the law criminalizing abortion was constitutional.
2018	Medical Service Act	The Medical Service Act was amended to reinforce the punishment of medical doctors who performed illegal abortions.
2019	Constitutional Court Decision on Articles 260 and 270	The Constitutional Court ruled that the ban on abortion was unconstitutional and that the abortion law must be revised by December 31, 2020.

Court ruled that Articles 269 and 270 of the Criminal Act were unconstitutional.[41] In the South Korean legal system, there are two types of decisions on constitutionality: "complete unconstitutionality" and "constitutional discordance."[42] For a law to be ruled as completely unconstitutional, a majority of justices (six of the nine justices) must determine that the law is unconstitutional. In this case, the law loses its effect immediately. However, because four of the nine justices determined that Articles 269 and 270 were in constitutional discordance, three deemed them unconstitutional, and two said they were constitutional, the articles were ruled to be in constitutional discordance. Thus, constitutional discordance means the law remains in effect until the National Assembly makes a new law within a designated timeframe (in this case, by the end of December 2020). If the National Assembly does not make a new law by then, the current criminal codes on abortion will lose their effect after December 2020. Meanwhile, although the criminal codes on abortion are technically still valid until December 31, 2020, the Supreme Prosecutors' Office announced in June 2019 that they would suspend prosecution related to abortion cases because the Constitutional Court had clearly established women's rights to terminate their pregnancies.[43]

As the court decision is being used as a reference point to create new discourses and develop new policies related to abortion in South Korea, it is important to examine the implications of the court decision carefully. First, the Constitutional Court confirmed that a woman's right to decide whether to have or not have a baby is a fundamental right guaranteed by the constitution and that it has an important effect on a woman's health and life. The court stated that self-determination includes a woman's right to autonomously form her own sphere of living on the basis of her dignity and, if she is pregnant, her right to decide whether she will keep her pregnancy. The justices emphasized that human beings should not be treated as a means for other values, purposes, or legal interests. These comments showed that the justices considered the historical context of Korea's population control policies when making their decision.[44]

Second, the justices noted that a woman's decision to terminate a pregnancy does not exist in a vacuum but is deeply related to her social, economic, and family conditions. They acknowledged that, for women, childrearing may require constant physical, mental, and emotional effort for nearly two decades and that women face a diverse and wide array of social and economic situations that can affect their childrearing. These burdens and difficulties can be compounded by social problems, such as gender biases, the patriarchal culture, and poor childcare conditions. Moreover, they stated that banning abortion proved ineffective in reducing abortions and, instead, harmed women's health and lives. As such, according to the justices, the blanket ban on abortion had not sufficiently protected the life and health of pregnant women.[45]

Third, the Constitutional Court emphasized the duty of the government. The justices described the unique relationship between pregnant women and fetuses, mentioning that they are independent from and yet dependent on each other. The justices advanced the opinion that a more desirable and effective means to achieve the goal of protecting life and human rights would be for the government to faithfully implement and strengthen sex education, conduct counseling and other measures, provide social welfare assistance for pregnant women and children, and resolve various institutional and social structural difficulties that impede childbirth and childrearing.[46]

As a result of these statements from the Constitutional Court, legislators were ordered to determine how to protect the lives of fetuses by substantially reducing the need for abortion while also guaranteeing women's right to self-determination and not simply prioritizing the life of the fetus over the self-determination of the pregnant woman. One of the significant differences between the 2019 and 2012 decisions is that the justices did not frame the abortion issue as a conflict between a pregnant woman and a fetus. While the 2012 decision ruled that the value of a fetus's life outweighs a woman's choice to have an abortion, the 2019 court decision focused more on the responsibilities of the government to women's reproductive rights and

lives. This court decision also reflected the pleading paper written by the defense counsel and the main arguments for reproductive justice publicized by Joint Action.

Conclusion

The main slogan in the recent reproductive justice campaign to abolish the criminal codes on abortion in South Korea was "If abortion is a crime, the state is the criminal." The reproductive justice movement, collectively represented by the activities and actions of Joint Action, has debunked the notion that seeking abortion care makes women criminals; instead, it places responsibility on the government for upholding and advancing reproductive rights in Korea. Since 2016, the reproductive justice movement's efforts to abolish South Korea's criminal codes on abortion strategically focused on reproductive justice by advocating for fundamental social change that would promote actual sexual and reproductive health and rights for everyone regardless of class, gender identity, sexual orientation, and marital status. Furthermore, Joint Action was effective in persuading people that the Korean anti-abortion law was not a matter of "life versus choice" but instead a governmental and social tool that 1) allowed the state to control reproductive rights and, ultimately, to cherry-pick the lives it deemed most worthy, and 2) regulated women's sexuality and behavior. By shifting the discourse related to reproductive issues, the movement had a stronger position in the legal fight against the state and established solidarity with other human rights organizations and groups.

The Constitutional Court's decision on the abortion ban represents a victory for the South Korean reproductive justice movement. However, the reproductive justice movement is still working to achieve a real victory. The day after the 2019 decision, Joint Action held a press conference at which they claimed that the government and National Assembly should decriminalize abortion completely.[47] They also demanded that the government prepare a new law to guarantee everyone's sexual and reproductive health and rights. Although the Constitutional Court decision was progressive, the government and members of the National Assembly still remain in the paradigm of punishment and restriction regarding abortion. In April 2019, the only progressive party in National Assembly, the Justice Party, submitted amendments to the Criminal Act and the Mother and Child Health Act.[48] In those bills, they limited abortion at a woman's request to within the first 14 weeks of pregnancy. For women between 14 and 22 weeks of pregnancy, they added that abortion would be legal on socioeconomic grounds, in addition to the existing limited exceptions listed in the Mother and Child Health Act.[49] In pregnancies more advanced than 22 weeks, they suggested that abortion is allowed only in cases of a woman's critical health problem.[50] Since there is no country except Canada that does not have any regulations regarding abortion, Korean lawmakers tend to refer to and follow the current abortion laws in other countries, such as Germany, rather than create a new model of law. Under these circumstances, Joint Action is working on the preparation of a bill for the complete decriminalization of abortion as well as protecting actual sexual and reproductive health and rights for every individual.

References

1. The official Korean name for the Joint Action for Reproductive Justice is Moduleul wihan nagtaejoe pyeji haengdong (모두를 위한 낙태죄 폐지 공동행동).

2. Sexual and Reproductive Rights Forum (Ed.), Battleground: Sexual and reproductive politics around the criminal codes on abortion law in South Korea (Seoul, South Korea: Humanitas, 2018).

3. H. Yang, "A journal of family law reform in Korea: Tradition, equality, and social change," J. Korean L. 8 (2008), pp.8-77; S. Kim and K. Kim, The Korean women's movement and the state: Bargaining for change (London: Routledge, 2014). U. Kim, "Gender equality legislation in Korea," Asian Journal of Women's Studies 13/3 (2007), pp. 109–131.

4. S. Kim, "Reproductive technologies as population control: How pronatalist policies harm reproductive health in South Korea," Sexual and Reproductive Health Matters 27/2 (2019), pp. 1–7.

5. S. Ji, "The Planned Parenthood Federation of Korea's provision of Menstrual Regulation from 1974 to 1990," Women's Studies Review 36/1 (2019), pp. 121–158.; E. Bae, Human reproduction in the Korean modernity (Seoul: Siganyehang,

2012).

6. S. Colen, "'Like a mother to them': Stratified reproduction and West Indian childcare workers and employers in New York" in F. D. Ginsburg, R. Rapp, and R. R. Reiter (Eds.), Conceiving the new world order: The global politics of reproduction (Univ. of California Press, 1995).

7. H. Kim et al., "Ingong-imsin-jungjeol siltae-josa min jonghap-daechaek surip" [Report on the current status of induced abortion and planning solution to prevent abortion] (Seoul: The Ministry of Health and Welfare, 2005).

8. E. Cho, "Self-perception of the non-West and historicism: The Family Planning Program in South Korea," Society and History 98 (2013), pp.121–153.

9. D. J. Hernandez, Success or failure? Family planning programs in the Third World (Westport, CT: Greenwood Press, 1984).; E. Bae, "Women's body and the state family planning programs in Korea: Examining 'the modern' in women's lives through the social history of birth control," Society and History 67 (2005), pp. 260–299.

10. H. Choi, "Problems with the abortion law and direction for improvement," Ewha Journal of Gender and Law 8/3 (2016), pp. 225–258.

11. Korean Statistical Information Service, Total fertility rates (1970–2016) (Daejeon: KOSIS, 2018). Available at http://kosis.kr/statHtml/statHtml.do?orgId=101&tblId=DT_1B81A21&vw_cd=MT_ZTITLE&list_id=A21_1&seqNo=&lang_mode=ko&language=kor&obj_var_id=&itm_id=&conn_path=E1.

12. Ministry of Health and Welfare, The master plan for the prevention of illegal abortion (Seoul: Ministry of Health and Welfare, 2005).

13. E. Kim, "Nag-tae jul-in-da-go jeo-chul-san geug-bog-doel-kka?" [Could we increase the birth rates by reducing the abortion rates?], Sisain (March 23, 2010). Available at https://www.sisain.co.kr/?mod=news&act=articleView&idxno=6708.

14. The Network for Women's Right to Decide Pregnancy and Delivery. Available at https://justice2011.tistory.com/.

15. Mother and Child Health Act, Article 14 (Limited Permission for Induced Abortion Operations).

16. *2010Hun-Ba402*, decided on August 23, 2012.

17. Sexual and Reproductive Rights Forum (Ed.), Battleground: Sexual and reproductive politics around the criminal codes on abortion law in South Korea (Seoul, South Korea: Humanitas, 2018), p. 115.

18. K. Kim, "mi-seong-nyeon im-sin-bu nag-tae-su-sul hu sa-mang … ui-sa jib-haeng-yu-ye hwag-jeong" [a teen pregnant woman died after an abortion … The doctor has been given a suspended prison sentence]," The Kyunghyang Shinmun (February 24, 2016). Available at http://news.khan.co.kr/kh_news/khan_art_view.html?artid=201602241601371&code=940301.

19. E. Kim, Curative violence: Rehabilitating disability, gender, and sexuality in modern Korea (Durham, NC: Duke University Press, 2017).

20. A. Smith, "Beyond pro-choice versus pro-life: Women of color and reproductive justice," NWSA Journal 17/1 (2005), pp. 119–140. L. Ross, "Understanding reproductive justice: Transforming the pro-choice movement," Off Our Backs 36/4 (2006), pp. 14–19. R. West, "From choice to reproductive justice: De-constitutionalizing abortion rights," The Yale Law Journal (2009), pp. 1394–1432.

21. R. Kranz, Reproductive rights and technology (Facts on File, 2002).

22. The Sexual and Reproductive Rights Forum. Available at http://srhr.kr/author/reproductiverightsforum/.

23. J. Shin, "Stronger law against abortion sparks debate," Korea Bizwire (October 12, 2016). Available at http://koreabizwire.com/stronger-law-against-abortion-sparks-debate/67900.

24. X. Symons, "South Korean doctors "protest" new abortion regulations," BioEdge (September 2, 2018). Available at https://www.bioedge.org/bioethics/south-korean-doctors-protest-new-abortion-regulations/12789.

25. J. Seok, "S. Korea's 'black protest' movement gaining momentum for abortion rights," the Hankyoreh (October 18, 2016). Available at http://english.hani.co.kr/arti/english_edition/e_national/766232.html.

26. Y. Kim & Y. Ahn, "Seeking decriminalization of abortion, women cry out "Hands off my uterus!"" The Hankyoreh (October 17, 2016) Available at http://english.hani.co.kr/arti/english_edition/e_national/766014.html Y. Do, "'Black Protests' call end to outdated abortion law," Korea Exposé (December 14, 2017). Available at https://www.koreaexpose.com/black-protests-abortion-south-korea/.

27. N. Young, "South Korea: Joint Action for Reproductive Justice formed and activities for 28 September," International Campaign for Women's Right to Safe Abortion (Newsletter, October 10, 2017). Available at https://www.safeabortionwomensright.org/south-korea-joint-action-for-reproductive-justice-formed-activities-for-28-september/.

28. S. Kwak, "Yeo-seong-deul-i 'im-sin jung-dan'eul seon-taeg-han ja-sin-ui gyeong-heom-eul i-ya-gi-ha-da (hwa-bo)" [Women talk about their abortion experiences (photoshoots)], The Huffington Post Korea (September 28, 2017). Available at https://www.huffingtonpost.kr/entry/story_kr_18124122.

29. M. Jung, "'Government distorted Pope's abortion stance,'" The Korea Times (November 18, 2017). Available at http://www.koreatimes.co.kr/www/nation/2018/11/119_240052.html.

30. J. Jin, "Yeo-seong-ui ja-gi-gyeol-jeong-gwon-gwa pyeong-deung-han salm-eul bo-jang-han gyeol-jeong-e ul-keog" [Choked up after hearing the constitutional decision to guarantee women's lives and right to decide], Womennews (April 19, 2019). Available at http://www.womennews.co.kr/news/articleView.html?idxno=188456.

31. S. Lee, "Korea's 65-year-old abortion ban under review," The Korea Times (May 21, 2018). Available at http://www.koreatimes.co.kr/www/nation/2018/11/119_249300.html.

32. H. Choi, "66 nyeon dong-an gyeong-heom-ha-ji mos-haess-deon sae-lo-un se-gye" [A new world that we haven't experienced in 66 years], Korean Lawyers for Public Interest and Human Rights (Newsletter, April 22, 2019). Available at http://hopeandlaw.org/승소소식-헌법재판소-낙태죄-조항-헌법불합치-결/.

33. C. Lee, "Abortion ban challenged at Supreme Court," The Korea Herald (May 25, 2018). Available at http://khnews.kheraldm.com/view.php?ud=20180524000955&md=20180527003142_BL.

34. W. Choi and H. Goh, "Him-deul-ji-man keun han geol-eum-tss-heon-jae-neun yeo-seong-ui gyeol-jeong-eul mid-eu-la-go haess-da" [It was tough, but it a big move . . . The Constitutional Court said, trust women], The Hankyoreh (April 12, 2019). Available at http://www.hani.co.kr/arti/society/society_general/889859.html.

35. G. Hwang, "[Interview] Women on Waves supports South Korea's legalization of abortion," The Hankyoreh (July 6, 2018). Available at http://english.hani.co.kr/arti/english_edition/e_international/852253.html.

36. S. Yoon, "Pro-choice activists see an opportunity for change: After the rise of the Me Too Movement, feminists have taken to the streets to make abortion legal," Korea JoongAng Daily (November 5, 2018). Available at http://koreajoongangdaily.joins.com/news/article/article.aspx?aid=3055118.

37. "#Sept28 International Action Day for Safe and Legal Abortion: A performance to repeal the Article 269 of the Criminal Code of South Korea" [안전하고 합법적인 임신중지를 위한 국제 행동의 날: 269명이 만드는 형법 제269조 폐지 퍼포먼스], YouTube video, 3:34, "Joint Action" (Oct. 2, 2018). Available at https://www.youtube.com/watch?v=NcH-gCINRuoI.

38. H. Yi, "South Korea refuses to accept U.N. recommendation to abolish the death penalty," The Kyunghyang Shinmun (March 19, 2018). Available at http://english.khan.co.kr/khan_art_view.html?artid=201803192055437&code=710100#csidxde2b763d-86826f59cafc923f21d2143.; H. Ock, "Candle revolution: how candles led to Park's impeachment," The Korea Herald (December 9, 2016). Available at http://khnews.kheraldm.com/view.php?ud=20161209000458&md=20170812014527_BL.

39. K. Shim, "Constitutional Court shuts doors," Korea JoongAng Daily (September 20, 2018). Available at http://koreajoongangdaily.joins.com/news/article/article.aspx?aid=3053435.

40. "Constitutional Court to decide on abortion: The Court should listen to the voice of the people," The Kyunghyang Shinmun (April 11, 2019). Available at http://english.khan.co.kr/khan_art_view.html?artid=201904011106247&code=790101.

41. *2017Hun-Ba127*, decided on April 11, 2019. Available at https://ecourt.ccourt.go.kr/coelec/websquare/websquare.html?w2xPath=/ui/coelec/dta/casesrch/EP4100_M01.xml&eventno=2017%ED%97%8C%EB%B0%94127&viewType=3&searchType=1.

42. J. Park, "The study on the issue of law about the Decision of Unconformable to Constitution as to the criminal clause around the Supreme Court ruling," Gachon Law Review 5/2 (2012), pp. 1–26.

43. E. Rhee, "Abortions still being carried out in the shadows," Korea JoongAng Daily (August 5, 2019). Available at http://koreajoongangdaily.joins.com/news/article/article.aspx?aid=3066325.

44. *2017Hun-Ba127*, decided on April 11, 2019. Available at https://ecourt.ccourt.go.kr/coelec/websquare/websquare.html?w2xPath=/ui/coelec/dta/casesrch/EP4100_M01.xml&eventno=2017%ED%97%8C%EB%B0%94127&viewType=3&searchType=1.

45. *2017Hun-Ba127*, decided on April 11, 2019.

46. *2017Hun-Ba127*, decided on April 11, 2019.

47. S. Yoon, "After historic abortion ruling, what comes next?: With ban abolished, both sides of the issue hope voices are heard," Korea JoongAng Daily (April 15, 2019). Available at http://koreajoongangdaily.joins.com/news/article/article.aspx?aid=3061818.

48. H. Ock, "After ruling on abortion ban in S. Korea, what now?" The Korea Herald (April 15, 2019). Available at http://khnews.kheraldm.com/view.php?ud=20190412000651.

49. S. Lee, S. Byun, J. Kim, et al., "In-gong-im-sin-jung-jeol sil-tae-jo-sa" [National research on abortion], (Seoul: Ministry of Health and Welfare, 2018).

50. The partial amendment of the Criminal Act, proposed by Lee Jung-mi, (April 15, 2019); The partial amendment of the Mother and Child Health Act, proposed by Lee Jung-mi, (Aprilg 15, 2019). The Joint Action for Reproductive Justice released a statement criticizing the bill of the Justice Party. Available at http://srhr.kr/2019/337/.

From the Grassroots to the Oireachtas: Abortion Law Reform in the Republic of Ireland

ANNA CARNEGIE AND RACHEL ROTH

Abstract

In 1983, voters inserted the Eighth Amendment into Ireland's constitution, equating the right to life of a fetus with that of a pregnant person. Hundreds of thousands of women were forced overseas to access basic health care and thousands more were forced underground, importing abortion pills and risking prosecution. The realities of life under the Eighth Amendment sparked a powerful feminist grassroots struggle for abortion access. This article charts the path to abortion law reform in the Republic of Ireland from the perspective of grassroots activists in the Abortion Rights Campaign (ARC). The first half highlights the national and international policy mechanisms that activists leveraged to bring Ireland's abortion regime to the point of reform, as well as the power of challenging abortion stigma to mobilize the public and politicians, culminating in a resounding vote in May 2018 to repeal the Eighth Amendment. The second half analyzes the legislation enacted in late 2018 in order to give effect to the vote. While the new law and its commitment to free abortion is a momentous step for Ireland, it also establishes a needlessly cumbersome regime that remains grounded in a criminal law framework and incorporates barriers that have no grounding in medical evidence.

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Introduction

"The state acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right."

—Eighth Amendment to the Irish Constitution, 1983–2018[1]

"I think it's important for us, for society, to be aware of the kind of trauma you can put someone through by putting their humanity up for a vote."

—Miriam Needham, abortion rights activist and playwright, 2019[2]

In 1983, the Irish electorate voted by referendum to change the country's constitution to all but ban abortion by equating the life of a fetus with that of a pregnant woman. Even though abortion was already illegal, conservative forces sought to cement the ban on abortion by embedding it in the nation's constitution.[3] This decision treated women as criminals, forced to travel to England for abortion care. As the years wore on and pregnant people suffered under the burdens of shame and financial hardship imposed by the constitution, the country's feminist activist base grew stronger and more vocal about the need for access to abortion at home. In this article, we describe abortion law reform in the Republic of Ireland from our on-the-ground perspective as members of the Abortion Rights Campaign (ARC). ARC is a grassroots, feminist, all-volunteer movement for change. From its inception, ARC has campaigned for access to abortion that is free, safe, and legal, without time limits or gatekeepers, for all who want or need it on the island of Ireland.

The first half of this article illustrates the profound damage wrought by the constitutional ban on abortion. It then examines the strategies of resistance that culminated in the successful vote to repeal the Eighth Amendment in May 2018. The second half outlines the major benefits and failings of Ireland's new abortion law, with a particular focus on the role of grassroots organizing in the fight to repeal the Eighth Amendment. ARC recognizes that a variety of people, including girls, women, transgender people, and nonbinary people, can become pregnant and need abortion care. We use the terms woman/women and person/people throughout this article.

Many groups played critical roles in the successful referendum. For instance, Doctors for Choice created a space for physicians who wanted to become providers. Lawyers for Choice produced incisive legal analysis, and many individual members traveled the country to speak at community meetings. The Coalition to Repeal the Eighth brought together more than 80 organizations to call for change. People who had been forced to travel abroad after learning their fetuses had serious anomalies founded Terminations for Medical Reasons; members who told their stories played a vital role in generating compassion among voters. These groups, and others that sprung up before the referendum, worked with and alongside each other. While this article focuses on the contributions of ARC, the struggle to repeal the Eighth Amendment was truly a collective one.

Histories of subjugation and strategies of resistance

Greetings from Ireland: failing to take action on abortion since 1992

The Eighth Amendment didn't just ban abortion; it ascribed a right to life to fetuses (or "the unborn") and equated that with the right to life of pregnant women (or "mother[s]"). Going further, the amendment promised to "defend and vindicate" this fetal right to life, ushering in an era of unprecedented harm to anyone who could become pregnant.[4] Although abortion was already prohibited in Ireland under the 1861 Offences Against the Person Act, the Eighth Amendment went a step further, guaranteeing that a change to abortion laws could only be achieved by another referendum.

This constitutional change did not happen in a vacuum. Rather, it was one of many aspects of a church-state apparatus intended to subjugate women that activists have long struggled to overcome.[5] Since Ireland's founding as an independent state in 1922, the Catholic Church has been a dominant political force, influencing a wide range of patriarchal social and public policies. As a practical matter, the

Eighth Amendment served to maintain this theocratic status quo. Under Ireland's Catholic-driven state ideology, a woman's primary role was that of a wife and mother. Female sexuality was shrouded in guilt, shame, and secrecy. Women who had sex outside of marriage, for example, were punished harshly. Generations of women were ostracized from wider society, incarcerated and forced to toil in Magdalene laundries—quasi-penal institutions run by nuns—the last of which did not close until 1996. These misogynistic structures have left a legacy of profound stigma around women's sexual and reproductive lives.[6]

Against the backdrop of church, state, and stigma, one factor that helped to maintain the status quo for so long is Ireland's proximity to England, where abortion is available. England is widely regarded as a "safety valve" that contributes to Ireland's low maternal mortality rate. Since 1980, more than 170,000 people are recorded as having travelled to another country—primarily England—for an abortion, often at great personal sacrifice and often through the generosity of charities like the Abortion Support Network.[7] These figures represent only those who gave an Irish address to health care providers abroad.

The consequences of the Eighth Amendment surfaced on numerous occasions over its 35-year existence. The X Case in 1992 highlighted the Irish state's punitive stance toward pregnant people. The case centered upon a 14-year-old girl who had been raped and was prevented by the Irish High Court from leaving the country for an abortion. The Irish Supreme Court overturned this decision and deemed the girl's life to be in danger through risk of suicide. The X Case prompted a referendum that inserted into the constitution an explicit provision on freedom to travel.[8] Such was the hypocrisy of the Irish state's attitude toward abortion: the exportation of reproductive health care was enshrined in law, while abortion at home was almost totally illegal.

As similar cases accumulated over the years, so too did frustration with the status quo. In June 2012, this frustration came to a head when an anti-choice group mounted a billboard campaign claiming "abortion tears her life apart"—referring to the oversized image of a fetus—and insisting "there's always a better answer." These billboards unleashed a new wave of anger and organizing to combat the deeply stigmatizing message that anyone who has an abortion has done something wrong.

A number of individuals decided to organize a public meeting in July 2012. Forty women and men met in a hotel in central Dublin and began to lay the foundations for an organization that would become known as the Abortion Rights Campaign (ARC). ARC aimed to achieve free, safe, legal abortion across Ireland, with repeal of the Eighth Amendment a central goal. Because anti-choice campaigners had succeeded in making abortion a constitutional issue that could only be redressed through a referendum, activists for change would have to address abortion stigma among all potential voters in addition to persuading politicians. Knowing that stigma-busting would be crucial to their success, members decided to put the word "abortion" front and center in their new organization's name.

A critical moment in the fight for Irish abortion rights occurred with the death of Savita Halappanavar. A 31-year-old Indian immigrant living in Galway, Ireland, Halappanavar was pregnant with her first child. Doctors refused to intervene after she was diagnosed with an incomplete miscarriage at approximately 16 weeks of pregnancy. Hospital staff told her and her husband that they could not do anything to expedite the miscarriage because a fetal heartbeat was still present, and Ireland was a "Catholic country." She died of sepsis from medical mismanagement of her condition.[9] This concrete example of the tremendous harm caused by the Eighth Amendment outraged huge numbers of individuals, who then mobilized to put mounting pressure on the government to address the problem.

The government's inaction became less tenable as activists made more people aware that it had never defined the terms under which women could legally access abortion care, as instructed to do 20 years earlier in the 1992 X ruling.[10] Moreover, Halappanavar's death occurred on the heels of the 2010 European Court of Human Rights ruling in

favor of three women who challenged Ireland's abortion laws (known as the ABC judgment); that court urged the state to enact legislation to broaden access to abortion.[11]

In 2013, the Oireachtas (Irish Parliament) passed the Protection of Life During Pregnancy Act (PLDPA) after a particularly brutal campaign where anti-choice activists harassed and threatened elected officials in a way that was not common in Irish politics on issues other than abortion.[12] This new law permitted abortion in an exceedingly narrow range of cases—namely, where two doctors were willing to certify that pregnancy put the life (as opposed to the health) of a woman at "real and substantial" risk, and three doctors if the risk is the prospect of suicide. Some anti-choice voices at the time tried to convince the public that the act would permit unfettered access to abortion. In reality, the PLDPA had little practical impact, resulting in fewer than 30 sanctioned abortions per year.[13] Moreover, the PLDPA imposed a criminal penalty of up to 14 years' imprisonment for anyone who either obtained an abortion in Ireland (for example, through obtaining safe but illegal pills), or provided an abortion outside of its parameters.

Several high-profile cases highlight the failure of the PLDPA to provide access in life-threatening situations. These include the case of Ms. Y, a pregnant asylum-seeker who had been raped in her home country and was denied an abortion in Ireland, even though doctors said she was suicidal and thus continuing the pregnancy posed a significant threat to her life. She was ultimately subjected to a forced Caesarean section to deliver the baby, as until 2019, Ireland's national consent policy denied pregnant individuals the same right to choose and refuse medical care as people who are not pregnant.[14] ARC opposed the PLDPA, seeing it as a wholly inadequate response to the ban on abortion and the constitutional subordination of pregnant people. ARC went on to campaign for a referendum to repeal the Eighth Amendment and build a nationwide network of grassroots activists who could be mobilized to fight for a referendum whenever that day came.

Invisible people have invisible rights

To break down abortion stigma, ARC organized values clarification and civic engagement workshops and trained people from around the country to host these events in their communities, as well as "speak outs" where individuals could share their abortion stories. ARC adopted an unapologetically pro-choice position in public spheres. The March for Choice that we organize each year around Safe Abortion Day in September has been called "the first openly pro-choice activity" in Ireland.[15] In 2012, 2,500 participants marched, and that number grew to a high of 40,000 in 2017. People wore jumpers and T-shirts emblazoned with the word REPEAL and ARC's slogan FREE SAFE LEGAL, creating visibility and fostering a sense of community among people who realized they were not alone.

One of ARC's core successes is the creation of regional networks across the country that worked tirelessly to break the silence and secrecy about abortion. The women and men in these networks set up information tables in quiet country towns and organized meetings and events, often being refused space in community gathering places because of the "contentious" nature of abortion. Regional groups' contributions were critical to the fight to repeal the Eighth Amendment, as evidenced by the extent of the yes vote across the country: 63% of people in rural areas voted yes, reflecting the national average, and the only constituency to vote against changing the constitution still voted 48% yes.[16]

Despite the gradual shift toward a pro-choice position among the Irish public, the government remained resistant to change on the matter of the Eighth Amendment; the ways in which it violated basic human rights was seemingly not a compelling enough argument. Fortunately, there were other influential audiences who were willing to listen—and moreover, to call on Irish legislators to act. ARC and other civil society organizations such as Amnesty International recognized that appealing to international human rights monitoring bodies could be an effective tactic to embarrass the state and press for legal and policy change. These bodies' proceedings shone a spotlight on Ireland's reproductive rights abuses and provided a formal mechanism to refute

anti-choice rhetoric about why abortion should remain illegal. They also provided advocates with opportunities to develop creative media messaging. For example, in 2014 one UN committee stated that Irish law treated people who were raped "as a vessel and nothing more." These observations attracted national media attention and ARC capitalized with the hashtag #NotAVessel on social media. This slogan quickly gained traction, with women all over the world posting pictures of themselves proclaiming #NotAVessel.[17]

From 2014, ARC participated in six UN proceedings. At least twice, ARC delivered joint statements on behalf of Irish civil society organizations. In 2016, ARC was the only organization advocating for abortion access at Ireland's examination under the Convention on the Rights of the Child. ARC's advocacy drew on first-person accounts from members who had travelled for abortion when they were adolescents.[18] During questioning, government representatives offered no reassurance on respecting adolescents' rights.[19] The committee's concluding observations called on Ireland to "decriminalize abortion in all circumstances."[20]

In addition to powerful recommendations by UN treaty monitoring bodies, the UN Human Rights Committee ruled that Ireland violated the rights of individuals who had no choice but to travel to access abortion care.[21] In one of these cases, the Committee ordered the state to compensate the individuals, and also

> *take steps to prevent similar violations occurring in the future. To this end the state party should amend its law on voluntary termination of pregnancy, including if necessary its constitution, to ensure compliance with the Covenant [and] take measures to ensure that health-care providers are in a position to supply full information on safe abortion services without fearing being subjected to criminal sanctions*.[22]

Proceedings in these various fora laid bare the conflict between Irish abortion law and international human rights standards. Although many of the high-profile cases focused on tragic situations of individuals faced with fetal anomalies, numerous recommendations by these bodies called for wider reform, from instructing the state to revise its abortion legislation and hold a referendum on the Eighth Amendment to calling for it to decriminalize abortion in all circumstances.[23] Without the submissions from grassroots organizations, some of these broader recommendations may never have been made.

The combination of strategies employed by ARC and other groups situated abortion in the forefront of public consciousness and moved it gradually from being a peripheral subject to an integral human rights issue. The increased profile of Ireland's restrictive abortion laws through the combination of awareness-raising, anti-stigma, and advocacy work put pressure on the Irish government from many sides.

Time to act!

This pressure on the government eventually produced some movement. In July 2016, the Oireachtas voted to establish a Citizens Assembly—made up of 99 randomly selected individuals—to deliberate on a number of issues, including the Eighth Amendment.[24] The assembly effectively allowed the government to claim to be responding to the UN, but offered no recourse to those whose rights continued to be violated.

ARC was skeptical of the assembly process, viewing it largely as a political delay tactic. First and foremost, human rights should not depend on public opinion. Additionally, the assembly process had no clear objectives and was not transparent about how speakers were to be selected. A preoccupation with "balance" meant that the assembly gave equal weight to facts and falsehoods. Religious bodies and extremist organizations were given a platform to debate the morality of abortion and perpetuate myths without any basis in science. Speakers cited discredited studies claiming that abortion is bad for women's mental health, and perpetuated abortion stigma by making comments about people killing their children.[25]

Despite these significant flaws, ARC decided to participate in the process. We held out some hope that, when presented with the realities of abortion in

Irish people's lives, assembly members would adopt a pro-choice position. ARC submitted a paper outlining the gold standard of barrier-free access to abortion which featured 60 personal testimonies, putting the views and experiences of those directly affected by the Eighth Amendment on the public record. ARC put out an open call for stories, which were sent to a dedicated email address. These first-person accounts described navigating the hurdles to traveling abroad for medical care and importing pills to induce an abortion, among other scenarios, and complemented submissions by other pro-choice groups focused on legal and medical arguments.

Up until this point, much of the political discourse on abortion rights in Ireland had centered on exceptions, such as providing abortion in cases of fatal fetal anomalies, or rape or incest. Because assembly members were recruited on the basis that they were strictly "impartial" —one potential member was even removed for having attended a vigil for Savita Halappanavar four years before— there was understandable concern that when faced with anti-abortion propaganda in equal measure to medical and legal evidence, they would gravitate toward recommendations on the more conservative end of the spectrum. Instead, they came to recognize the need for significant changes to increase access to abortion and advocated for these in their robust slate of recommendations. Legal scholar Fiona de Londras noted at the time that, "the Citizens Assembly took [political representatives] by surprise last weekend. In truth, it took many of us by surprise."[26] She also argues that the assembly "created the conditions for change" in "a political system that was not generally willing to accept that women and pregnant people were sufficiently expert in the harms of the 8th Amendment" to take its cues from them.[27] Having spent years reluctant to deal with abortion, the government took cover under the assembly's recommendations to put forward a motion for larger-scale reform.

However, they were not willing to embrace these recommendations entirely, and each step from the assembly onward diluted its calls for change. In 2017, an all-party Joint Oireachtas Committee considered the Citizens Assembly findings and testimony from a range of experts. The committee produced less robust recommendations than the assembly, which organizations like ARC challenged at the time. Nonetheless, the committee did recommend that a referendum be held on removing the Eighth Amendment, and the cabinet agreed to this step in January 2018. In the time it took the Citizens Assembly and Joint Oireachtas Committee to deliberate, more than 3,000 people travelled to England or Wales to access abortion services.[28]

ARC was one of three civil society organizations and the only grassroots group that formed Together for Yes (TfY), the official referendum campaign that launched on March 22, 2018, and concluded with the successful vote on May 25, 2018. ARC members made the decision to join the (as yet unnamed) TfY at an extraordinary general meeting in February 2018. The Coalition to Repeal the 8th and the National Women's Council of Ireland were the other founders. The TfY campaign emphasized compassion and caring for Irish women at home in Ireland, especially in such tragic situations as when a woman carrying a wanted pregnancy is told her fetus has a fatal condition. Working alongside these other civil society groups to form a coherent campaign involved ongoing negotiation and compromise over tactics and messaging.[29]

At the outset of the referendum campaign, the government released a Draft Heads of Bill to regulate abortion (a "general scheme" of a bill that outlines major provisions but is not fully fleshed out) on the theory that people wanted to know what they were voting for if they voted to remove the Eighth Amendment from the constitution. This draft was weaker still than both proposals preceding it, reflecting behind-the-scenes political maneuvering. For example, it included a mandatory three-day waiting period, something which had been rejected by both the assembly and the committee but was widely perceived as necessary to gain the approval of the Tánaiste (Deputy Prime Minister). While campaigners were quick to see the problems in the draft bill and tried to counteract them with evidence-based discourse (such as blog posts outlining the negative impact of waiting periods), we had limited power to influence immediate

changes. All our energy was devoted to securing a yes vote. Campaigners shared an implicit assumption that we could address the problems after winning the referendum.[30] Some also feared that disturbing the "united front" between Together for Yes, political parties, and the government might cost success in the referendum, especially given the pervasive narrative on the part of the media, general public, and the yes campaign itself that this would be a close-won fight.

Abortion under Ireland's new law: free, mostly safe, but still criminalized

The hard work has just begun

For four months following the referendum, several anti-choice activists filed legal challenges to the results, delaying the government's ability to formally remove the Eighth Amendment and introduce legislation to allow for abortion services. ARC organized a meeting with other pro-choice groups to discuss the draft legislation and spent the following months developing an affirmative vision of the principles underlying good abortion law and provision: bodily autonomy, accessibility, accountability, and evidence.[31] With these ideals as the basis, we then chose specific policy priorities to mobilize around. They included:

- free universal abortion care
- full decriminalization
- no mandatory waiting period
- no refusal of care ("conscientious objection") and
- no vague non-medical criteria, such as "serious" risk to health.

Along with supportive politicians, ARC hoped that the strength of the 2-to-1 (66.4%) yes vote would translate into leverage to improve the government's bill.[32] When the government formally introduced its legislation, however, it reflected very few of the changes the advocacy community had put forward to improve the initial draft. Further, the government rejected virtually all amendments to improve access during the legislative process. The rationale for rejecting them was generally some version of "we have to stick to what the people voted for." Minister of Health Simon Harris, however, did find space to make certain changes. One welcome change he included, when the bill was introduced in September 2018, was to make abortion free. This squarely reflected ARC's priorities, but he rejected relatively simple changes like using gender-inclusive or gender-neutral language despite a wave of grassroots and even mainstream political party support.[33] He also rejected restrictive amendments proposed by opponents of repeal.

By publicly dressing down the anti-choice legislators when rejecting their amendments, Harris positioned himself as a champion for women while simultaneously endorsing anti-choice measures such as a mandatory waiting period. The health committee hearings and debates in the Dáil and Seanad (the Irish Houses of Parliament) became painful exercises in repetition, as the same appeals to evidence and human rights were rejected over and over again. The cabinet had resolved not to accept changes to the "draft" bill introduced and party discipline among the two primary political parties, Fine Gael and Fianna Fail, meant that there were not enough other members of parliament to push through rights-enhancing amendments.[34] Many activists had given everything they had to campaigning for a yes vote in the May referendum and were not as involved in legislative advocacy. Only a few organizations (primarily ARC, Amnesty Ireland, the Irish Family Planning Association, and Lawyers for Choice) were engaged actively. In the end, we won only one of our key priorities: free abortion services.

Ireland's president signed the abortion bill into law on December 20, 2018, just days before the minister of health had promised abortion services would begin.[35] While the new law is a momentous step for Ireland, it also establishes a needlessly cumbersome system that remains grounded in a chilling criminal law framework, heavily restricts abortions after the first trimester, and erects barriers that serve no legitimate purpose.

Key features of the new law

The law and clinical guidelines establish free abortion, which is available on request or "without specific indication" for the first trimester. Ireland does not have a universal health care system and offers relatively few universal health benefits, so the government's decision to make abortion free is especially impressive. In the run-up to the referendum, many politicians, including the Taoiseach (prime minister), said that abortion should be "safe, legal, and rare." By the end of the legislative debates, the minister of health adopted ARC's reasoning that abortion isn't truly safe if it isn't free.[36] Free abortion is thus a material victory and a rhetorical one.

Sorting out exactly who can access abortion care without cost has been a challenge, however. Typically, doctors are reimbursed via a patient's Personal Public Service (PPS) number; however, not all legal residents have a PPS number—for example, students from abroad—let alone undocumented residents. Advocates for asylum seekers have asked for clarification on whether the government will provide free abortion care, and on navigating logistical challenges unique to this group, whom the government houses primarily in smaller towns and who have limited ability to travel. Residents of Northern Ireland were left out of the 2018 law, despite politicians' promises and the fact that they can ordinarily receive medical care in the Republic.

Abortion on request during the first trimester is a narrower victory than it may at first appear. Taking all provisions together, people can access abortion without having to meet specific criteria for up to 12 weeks since the first day of their last menstrual period (LMP). They must see a doctor to certify on government-issued paperwork that their pregnancy is under the time limit, and then wait three days before returning for the abortion, which is typically administered in the form of medical abortion pills. Medical and legal experts, not to mention pro-choice activists, have consistently testified against a mandatory delay, arguing it is paternalistic and without clinical benefit.

In keeping with the World Health Organization's good practice guidelines, the focus of Ireland's new system is on providing care in the community, that is, in doctors' offices or the handful of independent women's health clinics in Dublin. The Irish Health Service Executive (HSE) established a website and telephone line called MyOptions to help people find a provider.[37] The promise of this model will take time to realize. As of September 2019, more than 300 doctors had opted to provide abortion care, but about half offer care only to their own patients; only 10 of 19 maternity hospitals are providing any abortion care at all.[38] As expected, providers are not evenly distributed across the country, leaving people in rural areas without nearby services—a hardship given poor public transportation.

Even doctors who are eager to participate in this community-led system face limitations. The Department of Health only allows doctors to provide abortion care up to nine weeks LMP.[39] After that, they must refer patients to a hospital, even though health professionals can safely provide abortion care in the community well into the second trimester. In both settings, medical abortion is the norm. Indeed, the government's rhetoric has consistently sanitized abortion care by focusing on the provision of pills. If the government committed to training and supporting doctors to provide aspiration abortion, then doctors could care for more patients in their offices, significantly expanding community-based care.

The emerging consensus is that the system works well for those who realize very quickly that they are pregnant and who do not need dating scans to assuage doctors' fears of violating the law. For those who are past nine weeks LMP, or whose weeks since their last menstrual period needs to be verified, referrals to ultrasound providers and hospitals can be problematic, especially outside the bigger cities. Making matters worse, many home pregnancy tests give estimates of pregnancy based on conception, not LMP, leading people to think they have more time to obtain an abortion than they do. As the medical director of the Irish Family Planning Association put it, "When we get someone who thought they were eight, nine weeks, and turns out to be 11-plus, it becomes a panic to try and get them an appointment on time. It really

does; there is no other way I can describe that."[40]

The Act mandates a review into the operations of the law after three years. This review is one of the only amendments to the legislation that won government approval. While it was frustrating to watch government officials dismiss objections by saying they could be reviewed in the future, advocates welcome the guaranteed opportunity to push for improvements.

The long shadow of criminalization

As this discussion of the new system suggests, the law is riddled with problems. While the government campaigned by promising to "trust women" and "trust doctors," the law they crafted maintains abortion as a criminal matter, carving out specific permissible exceptions. In addition to the 12-week "early abortion" on request period, these exceptions are:

- abortion in cases of risk to life or of serious harm to the health of the pregnant woman, provided that two doctors, one being an obstetrician, certify that there is such risk, that the fetus has not reached viability and it is appropriate to carry out the abortion to avert that risk
- abortion in an emergency, that is, if there is an immediate risk to the life, or of serious harm to the health, of the pregnant woman and it is immediately necessary to carry out the abortion to avert that risk, as certified by the medical practitioner before or within three days after the termination
- abortion in cases where two medical practitioners, one being an obstetrician, certify that the fetus suffers from an abnormality that will lead to its death either before or within 28 days after birth.

Doctors who provide care outside these terms continue to risk arrest, prosecution, and a long prison sentence—just as they did when abortion was barely legal.

ARC vigorously opposed the criminal framework of the legislation. Abortion is health care and should be regulated under health statutes and codes for medics as well as patients. While the new law takes a major step by removing criminal penalties against individuals who terminate their own pregnancies, treating abortion as a crime stigmatizes people who decide to end a pregnancy and has a chilling effect on health care providers.[41]

An example of the controversy over the meaning of "12 weeks" illustrates the chilling impact of criminalization. One month after the introduction of legal abortion, the CEO of Dublin's Rotunda Maternity Hospital, Dr. Fergal Malone, explained that the hospital was limiting its early abortion service to 11 weeks LMP instead of 12, because "the legislation is written with an upper limit of 12 weeks and zero days. But there is considerable ambiguity as to whether 12 weeks means the date at which the termination starts, or the date at which the termination ends." "Given there is a potential 14-year jail term for getting this wrong," he continued, "I can't put my staff in danger where there is ambiguity."[42]

After directing the hospital to provide care up to 12 weeks, the HSE took three more months to clarify that an abortion need not be completed by 12 weeks and zero days so long as it began by that deadline.[43] Should the medication fail to work, hospitals are barred from providing further treatment. This means that the person who has already jumped through all the hoops of having their pregnancy scanned and certified, waiting three days to go to the hospital for care, and then enduring a failed medical procedure, still must leave the country in order to terminate their pregnancy.[44]

As Dr. Malone's comments show, the new law is not entirely clear regarding what constitutes criminal conduct. It uses vague phrases instead of standard medical terms. The government insisted on the modifier "serious" in the framework of exceptions: abortion after 12 weeks since the last menstrual period may be provided if there is risk of "serious" harm to the health of the pregnant woman. All the medical and legal experts who participated in the various assemblies and committees urged the government against such vague, non-medical language. Indeed, within the first month of legal abortion, at least one woman and her partner went public about having to travel to England to access

abortion care when her fetus was diagnosed with life-threatening anomalies that the hospital would not certify as "fatal."[45] The fact that Ireland was a late adopter of legal abortion should have enabled the state to learn from patient-centered, international best practices, especially given the weight of the public vote in favor of reform.

During parliamentary debate, Health Minister Harris asserted that criminalization "is necessary from a policy perspective…The provisions in the Bill protect people from forced abortions or an attempt to intimidate women…It is important that the termination of pregnancy remains illegal outside the circumstances in which it is legal."[46] Harris rested his case on advice from the attorney general; however, such advice is confidential and not shared with members of the Oireachtas, let alone the public. Lawyers for Choice and other experts countered by saying that Ireland already has laws to deal with coercion and medical wrongdoing and proposed narrowly tailored measures to address the minister's stated concerns.[47]

Criminalization emboldens opponents of legal abortion to engage in "sting operations" or malicious reporting of doctors, in turn discouraging doctors from providing care and making abortion less accessible to those who need it. While doctors and patients are required to navigate a criminal framework for abortion care, rogue agencies that promote anti-abortion myths alongside free ultrasounds operate without regulation.[48] The Irish public is still waiting for long-promised legislation to regulate such agencies.[49]

Finally, Ireland's new abortion law never uses the word "abortion." Instead, the law concerns "termination of pregnancy," defined as "a medical procedure which is intended to end the life of the foetus." This troubling definition personifies fetuses, evokes a criminal offense, and stigmatizes the medical care that is supposedly being legitimized.[50] Rather than affirming women's rights after decades of reproductive oppression, this approach perpetuates the idea that abortion is, at the least, a moral crime.

Conclusion: The fight is far from won

In this first year of legal abortion, thousands of people have accessed abortion care in Ireland (the government will publish data in June 2020). However, others continue to travel abroad, including those who miss the 12-week cutoff and those who receive a diagnosis of catastrophic but not necessarily "fatal" fetal abnormality.[51] We do not yet know how many people are receiving the MyOptions announcements or how often pregnant people are being refused referrals by doctors. We also know very little about how the system is working for those whose pregnancies endanger their health.

As many predicted, the shortcomings in the new law are having their worst impact on those who have the fewest resources to overcome them. Consider young women or anyone with irregular periods who doesn't realize right away that they are pregnant. Or consider the plight of pregnant people who miss the deadline for abortion on request but cannot travel—for lack of funds, travel documents, or control over their lives (such as young people, people with disabilities who need a travel companion but cannot afford the cost of two plane tickets, asylum seekers who are subject to strict travel limitations, or those in controlling relationships). To their credit, some doctors go above and beyond to ensure that their patients get all required appointments in time to meet the cutoff, but how much better would care be if there were no artificial deadline at all?[52]

Despite these concerns, it is tremendously gratifying to know that on any given day, someone who is pregnant in Ireland and does not want to be has a chance to access free abortion care in their own country, and that activists had such a fundamental role in ushering in this change. ARC's influence on public policy is reflected not only in the fact that free abortion on request is now a reality for a sizeable number of people in Ireland, but also in the discourse of policymakers. The default political position has shifted radically, as evidenced by the health minister's acceptance that abortion is only safe when free, and by other politicians using the expression that abortion should be "free, safe, legal."

We firmly believe that our role as activists is not to bask in the success of what Ireland has achieved so far but to keep working to make things better. We plan to monitor the law and services so that we can advocate for improvements when the government undertakes its review, and to extend solidarity to our allies globally. Our fight is not won until free, safe, legal, and local abortion is a reality for all.

Postscript

Because the law is so new, the situation in Ireland is constantly evolving, as is the situation in Northern Ireland. To keep up to date, visit our website (https://www.abortionrightscampaign.ie/) and follow Alliance for Choice (http://www.allianc4choice.com/) in the North.

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References

1. Article 40.3.3 of the Irish Constitution is typically referred to as the Eighth Amendment.

2. A. McMenamin, "'Compostela' Looks at the Comedown after Repealing the Eighth," *Dublin Inquirer* (August 7, 2019).

3. F. de Londras and M. Enright, *Repealing the 8th: Reforming Irish abortion law* (with postscript) (Bristol: Policy Press, 2018), pp. 3-4; L. Field, "The abortion referendum of 2018 and a timeline of abortion politics in Ireland to date," *Irish Political Studies* 33/4 (2018), pp. 609-10.

4. Article 40.3.3, The Irish Constitution (the Eighth Amendment).

5. C. Hogan, *Republic of shame: Stories from Ireland's institutions for 'fallen women'* (London: Penguin, 2019).

6. Hogan (see note 5).

7. Ó. Ryan, "Q&A: Here's how many women and girls travel to the UK for abortions," *The Journal* (May 7, 2018).

8. Field (see note 3), pp. 608-628.

9. Republic of Ireland, Health Service Executive, *Investigation of Incident 50278 from time of patient's self referral to hospital on the 21st of October 2012 to the patient's death on the 28th of October, 2012* (June 7, 2013). Available at https://www.hse.ie/eng/services/news/nimtreport50278.pdf.

10. Field (see note 3).

11. European Court of Human Rights, *A, B and C v. Ireland* (2010), Communication No. 25579/05 (2010).

12. H. O'Connell, "Taoiseach: I'm being branded a murderer and getting letters written in blood," *The Journal* (June 12, 2013).

13. Department of Health Ireland, *Notifications in accordance with section 20 of the Protection For Life During Pregnancy Act 2013: Annual Report 2016.* (Dublin: Department of Health, 2017). Available at https://health.gov.ie/wp-content/uploads/2017/06/PLDP-Annual-Report-2016.pdf.

14. Amnesty Ireland, *Ms. Y's case: Denied a lawful abortion in Ireland.* (Dublin: Amnesty Ireland, 2016). Available at: https://www.amnesty.ie/ms-ys-case/; Republic of Ireland, Health Service Executive, *National Consent Policy* (2019), sections 1.4, 3.5, and 7.10. Available at https://www.hse.ie/eng/about/who/qid/other-quality-improvement-programmes/consent/.

15. A. Daly (Independent), Statements on the Referendum, Oireachtas (May 29, 2018); transcript available at https://www.oireachtas.ie/en/debates/debate/dail/2018-05-29/15/.

16. RTÉ Behaviour and Attitudes Exit Poll (May 25, 2018), available at https://static.rasset.ie/documents/news/2018/05/rte-exit-poll-final-11pm.pdf.

17. G. Wilentz, S. Corcoran, and N. Elster, "I'm #NotAVessel: The impact of grassroots pro-choice activism on Ireland's UN treaty monitoring body examinations," *The Irish Community Law Development Journal* 5/2 (2016), pp. 25-32.

18. Ibid.

19. "Committee on the Rights of the Child considers the report of Ireland" (press release), United Nations Office of the High Commissioner on Human Rights (January 14, 2016), available at https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=16952&LangID=E.

20. Committee on the Rights of the Child, Concluding Observations on Ireland, UN Doc. No. CRC/C/IRL/CO/3-4 (2016), para. 57-58.

21. UN Human Rights Committee, *Mellet v. Ireland*, UN Doc. No. CCPR/C/116/D/2324/2013 (2016). See also UN Human Rights Committee, *Whelan v. Ireland*, UN Doc. No. CCPR/C/119/D/2425/2014 (2017).

22. Ibid. Mellet, para 9.

23. F. de Londras, "Fatal foetal abnormality, Irish constitutional law, and *Mellet v Ireland*," *Medical Law Review* 24/4 (2016), pp. 591-607.

24. Field (see note 3).

25. See, e.g., Dr Helen Watts' presentation, "The moral status of the foetus," January 7, 2017. All proceedings,

submissions, and recommendations available at Citizens Assembly, Welcome to the Citizens Assembly, https://www.citizensassembly.ie/en/. See also Field (note 3).

26. F. de Londras, "Politicians left with nowhere to hide on abortion," *The Irish Times* (April 26, 2017).

27. F. de Londras, *The Citizens' Assembly and the disciplining of activist demands* (November 26, 2018). Available at https://blog-iacl-aidc.org/blog/2018/11/26/the-citizens-assembly-and-the-disciplining-of-activist-demands.

28. HM Government, *Abortion Statistics in England and Wales: 2017* (London: Department of Health and Social Care, 2018). Available at https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2017.

29. While the Together for Yes campaign is not the subject of our article, many others will be publishing about it over the next few years. See M. Enright, "'The enemy of the good': Reflections on Ireland's new abortion legislation," *Feminists@Law* 8/2 (2018), pp.1-12, see also the campaign website at https://www.togetherforyes.ie/.

30. Ibid, Enright.

31. Abortion Rights Campaign Submission on the Health (Regulation of Termination of Pregnancy) Bill 2018.

32. RTÉ (see note 17).

33. Advocates and politicians alike argued for gender-inclusive language to comply with The Gender Recognition Act 2015, which codifies certain rights of transgender people in Ireland.

34. A. Loughlin, "Simon Harris expected to compromise on number of changes in abortion bill," *Irish Examiner* (November 9, 2018); media reports of compromise turned out to be premature, however. See also Enright (note 29).

35. All proceedings and submissions regarding The Health (Regulation of Termination of Pregnancy) Act 2018 are available at https://www.oireachtas.ie/en/bills/bill/2018/105/

36. J. Bray, "Simon Harris clashes with anti-abortion TD during Dáil debate," *The Irish Times* (November 27, 2018).

37. World Health Organization, Medical management of abortion (Geneva: WHO, 2018). Republic of Ireland, Health Service Executive, MyOptions (2019), available at https://www2.hse.ie/unplanned-pregnancy/.

38. C. Hogan, "Why Ireland's battle over abortion is still far from over," *The Guardian*, (October 3, 2019).

39. Enright (see note 29), p.3.

40. C. Reilly, "Introducing abortion: The story so far," *Medical Independent* (March 25, 2019).

41. In Poland, for example, doctors operating under the country's restrictive law told a woman that continuing her pregnancy to term could result in losing her eyesight but would not authorize an abortion; *Tysiac v. Poland* (European Court of Human Rights, 2007). J. Erdman, "Theorizing time in abortion law and human rights." *Health and Human Rights* 19/1 (2017), pp. 29-40.

42. J. Bray, "Abortion in Ireland: Four weeks in, how's it working?" *The Irish Times* (January 26, 2019).

43. J. Bray, "Abortion clarity given to Rotunda Hospital," *The Irish Times* (May 5, 2019).

44. Reilly (see note 40).

45. K. Holland, P. Cullen, and J. Bray, "Woman refused abortion says she was told of fatal abnormality," *The Irish Times* (January 19, 2019).

46. S. Harris, Dáil Debate (November 28, 2018); transcript available at https://www.oireachtas.ie/en/debates/debate/dail/2018-11-28/33/.

47. For example, this "last-ditch" intervention by Lawyers for Choice: F. de Londras, et al., "Amending the Health (Regulation of Termination of Pregnancy) Bill: Five missed opportunities" (November 29, 2018). Available at https://lawyers4choice.ie/2018/11/29/amending-the-health-regulation-of-termination-of-pregnancy-act-5-priority-issues-for-the-seanad/.

48. E. Coyne and R. Lumley, "Sex kills, anti-abortion clinic tells women," *The Times Ireland* (April 3, 2017).

49. Ibid.

50. For more information, see Abortion Rights Campaign, *The Misuse of Criminal Law Regarding Abortion in Ireland and Northern Ireland* (Dublin: Abortion Rights Campaign, 2019). See also the substantial body of work by members of Lawyers for Choice, including the website https://about-the8th.com/, as well as de Londras and Enright (see note 3), and R. Fletcher "#RepealedThe8th: Translating travesty, global conversation, and the Irish abortion referendum," *Feminist Legal Studies*, 26/3 (2018), pp. 233–259.

51. M. Clarke, "The law and resulting provision are leaving too many people behind" (presentation at the Abortion Rights Campaign 8th Annual March for Choice press conference, Dublin, Ireland, September 26, 2019). Available at https://www.abortionrightscampaign.ie/2019/09/28/mara-clarke-the-law-and-resulting-provision-are-leaving-too-many-people-behind/.

52. Reilly (see note 40).

Abortion in Chile: The Long Road to Legalization and its Slow Implementation

GLORIA MAIRA, LIDIA CASAS, AND LIETA VIVALDI

Abstract

Until as recently as September 2017, Chile was one of the few countries in the world that did not permit abortion under any circumstances. Although the Health Code had permitted therapeutic abortion (i.e., on health grounds) from 1931, this was repealed in 1989 as one of General Pinochet's last acts in office. It took more than 25 years to reverse the ban. Finally, a new act was approved allowing abortion on three grounds: when a woman's life is in danger, when there are fetal anomalies incompatible with life, and in the case of rape. Since the law allows abortion only in limited cases, most women must continue to seek illegal abortions, as previously. In this paper, we explore the historical context in which Chile's 2017 bill was finally passed. We then analyze the legislative debate leading up to the passage of the law. Lastly, we present the results of a community-based participatory research effort carried out by an alliance between feminist and human rights organizations. Chile's law was passed almost two years ago, and this research shows the persistence of various obstacles that hinder women's access to legal abortion, such as the use of conscientious objection, a lack of trained health care providers, and a lack information for women.

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Introduction

Until as recently as September 2017, Chile was one of the few countries in the world that did not permit abortion under any circumstances. Although the Health Code had allowed therapeutic abortion (i.e., abortion on health grounds) beginning in 1931, the law was repealed in 1989 as one of Pinochet's last acts in office, leaving women to seek terminations clandestinely. There were several attempts to amend the abortion law, but none of them were successful until 2017, when the law was changed to allow abortion on three grounds: when a woman's life is in danger, when there are fetal anomalies incompatible with life, and in the case of rape. Since the law permits abortion only in these limited cases, most women with an unwanted pregnancy must continue to seek illegal abortions.

The law establishes several requirements to access an abortion: in the cases of risk to life and fetal anomalies, these conditions must be confirmed by a medical team (one doctor for the first category and two doctors for the latter). In the case of rape, the confirmation must come from a team composed of a social worker and a psychiatrist or clinical psychologist. There are no time limits established for the first two grounds. In the case of rape, the time limit is 12 weeks for women over 14 years old, and 14 weeks for those younger than 14. The law also introduced a two-person professional team (known as *dupla* in Spanish) consisting of a social worker and a psychologist to provide information and support to women during the clinical decision-making process and to provide, if requested, accompaniment during the abortion. Following the law's passage, the Ministry of Health drew up clinical guidelines and protocols to be used for the procedure.[1]

The law requires the approval of a doctor to confirm that the legal requirements are met for life-health risks and fetal anomaly, and in the case of rape a psycho-social team confirms the pregnancy gestational age and coherence of the statement regarding the rape. As part of the regulations attached to the law, public health services must guarantee access to legal terminations of pregnancy through 69 specialized high-risk obstetric units. The primary care system has become the gateway to identify and provide information to women who are eligible for an abortion on any of the three legal grounds and to refer them to a hospital where there is a high-risk obstetric unit.

To date, the implementation process has faced many challenges. First, since the law's passage, many clinicians have expressed conscientious objection and refused to implement the law. Second, all legal abortions must take place in high-risk obstetric units (although medical abortion pills can be used in the case of rape). Third, in March 2018, when the implementation phase was just getting off the ground, Chile changed governments from a center-left coalition (which had introduced the law and managed to secure its approval in Congress) to a right-wing alliance that had fervently opposed the law and was now doing what it could to prevent its successful implementation.

This paper starts by start by reviewing the historical context of the Chilean feminist movement's struggle to advance reproductive rights generally and abortion rights specifically, as well as the road to the legalization of abortion on three grounds in 2017. Despite the law's limitations, it was considered a milestone regarding women's rights in Chile, given that abortion had been completely banned since 1989. Hence, the law has an important symbolic power both culturally and politically.

Second, we present a reflection on the legislative debate and the challenges facing the implementation of the new law. In particular, we analyze lawmakers' discussion of central issues during the legislative debate: medical confidentiality, time limits for abortion, and the regulation of conscientious objection. We also explore limits of the law's implementation by drawing on the results of a community-based participatory research project carried out by La Mesa Acción por el Aborto (known as La Mesa) and Fondo Alquimia in alliance with women's groups in seven locations: Desnudando in Aysén; Observatorio de Género, Salud y Pueblo Mapuche in Araucanía; Marcha Mundial de Mujeres in Biobío and Santiago; Matriavisión in Valparaíso; Resueltas del Valle in Huasco; and Qispy Wayra in Antofagasta. The process was led by Gloria Maira and Lieta Vivaldi collaborated in

the final analysis and report.

Finally, we discuss some implications of having a restrictive law, the use of conscientious objection, and the organization and delivery of abortion services.

Historical context

In the early 20th century, the fight for abortion in Chile involved both the medical community and the feminist movement. The medical community recognized poverty and child mortality and the impact of clandestine abortion as an important health risk for women.[2] In 1931, therapeutic abortion was legalized via the Public Health Code, and shortly after (1936), a group of physicians from the Chilean Medical Association proposed legalizing abortion for socioeconomic reasons, though this was not approved.[3] Their argument was that allowing only therapeutic abortion would not deal with most clandestine abortions, which remains true to this day in spite of the current reform.

Meanwhile, the women's movement started to articulate its demands regarding legal abortion. The Movimiento pro Emancipación de la Mujer Chilena (founded in 1935), fought for women's suffrage and promoted women's reproductive rights as an integral part of political and economic equality for women.[4] From the beginning, it advocated for access to family planning and the legalization of abortion. The group claimed that "with respect to our biological bodies, our actions will not stop until we call the attention of scientific and legal authorities to the distress caused to poor working women who are forced to get pregnant and to give birth repeatedly."[5]

Abortion was subsequently submerged as an issue for feminists but reappeared 25 years later thanks to members of the medical community concerned with high rates of maternal morbidity and mortality due to clandestine abortion. The government introduced family planning in the 1960s to tackle the problem.[6] The organization most involved with women's reproductive health and collaborating with the national family planning program was the Chilean Association for the Protection of the Family (APROFA), which has been affiliated with the International Planned Parenthood Federation since 1967.

Legal abortion was not part of feminists' demands under Salvador Allende's socialist government (1970–1973). However, members of the medical community led a process to liberalize abortion through medical practice. In the Barros Luco Hospital, the team of obstetrician-gynecologists serving a working-class Santiago district began to perform legal abortions based on the understanding that they were "therapeutic" because poor women with unwanted pregnancies would otherwise seek high-risk abortions and possibly die as a result. From March to September 1973 alone, it is estimated that this hospital carried out approximately 3,000 abortions.[7]

Initial steps toward an abortion law

In 1973, the dictatorship introduced pro-natalist policies, and by 1989, abortion was prohibited under all circumstances: "No action will be taken in which the aim is to cause an abortion."[8] That same year, a national reproductive rights network—the Foro Abierto de Salud y Derechos Sexuales y Reproductivos—was established. This network, which consisted of 30 women's organizations, began promoting a bill to legalize abortion. However, during the 1990s, political interest in introducing legal reform on abortion was virtually nonexistent, and none of Chile's political parties supported this initiative. In fact, the only bill introduced to reinstate the repealed law on therapeutic abortion was never even tabled for debate.

During this period, the international context regarding sexual and reproductive rights changed. In Latin America, a regional campaign to decriminalize abortion—the Red de Salud de las Mujeres latinoamericanas y del Caribe—was launched. At the global level, two United Nations conferences (Cairo in 1994 and Beijing in 1995) were influential in promoting changes on abortion law reform.[9] In Chile, specific events revealed the strength of a new narrative on reproductive rights.[10] For example, in 2010 an abortion hotline was launched, providing women with information on how to use the abor-

tion pill safely and effectively at home. Moreover, in 2008, an articulate women's defense of the distribution of the morning-after pill called for a massive rally, the *Pildorazo*.[11]

Between the early 2000s and 2012, 11 bills were presented in Parliament that would have permitted abortion in some circumstances.[12] Furthermore, the election of a right-wing government in 2010 led to political activity that permitted the issue of abortion to come to the forefront. In 2011 alone, three bills seeking to partially legalize abortion were tabled in the Senate, but all three were rejected in April 2012.[13]

Michelle Bachelet became president again in 2014, supported by the coalition Nueva Mayoría. Active feminist members of this center-left coalition forced the inclusion of abortion in Bachelet's government program.[14] From their perspective, Bachelet's former role as head of UN Women and the perceived willingness of different political actors to consider the legalization of abortion presented an important opportunity. Within the coalition, the progressive members wanted to legalize abortion on demand, but the most conservative members would not to go farther than permitting abortion on the three grounds the country now has. The bill that was ultimately proposed represented a middle ground. For the first time since 1931, a Chilean president was ready to introduce a bill.

During this same period, La Mesa was taking shape, changing from a loose network of individuals and organizations to a structured coalition. There were quite different views within this coalition on the political impact of the abortion bill and the strategies needed to achieve the decriminalization and legalization of abortion. On the one hand, some considered the bill so restrictive that it made no sense to support its passage, because it would not change the lives of women with respect to their right to choose or change the illegal status of most abortions. On the other hand, others, although cognizant that the bill was restrictive, argued that it would allow for the protection of the lives and agency of at least some women and would be an opportunity to open a public debate on abortion.[15]

In addition, among those who supported a liberalization of the abortion law, some supported free and legal abortion while others did not care whether there would be government-provided services, positioning themselves as supporters of self-induced medical abortion. In this context, a combination of feminist and human rights organizations and individuals (both academics and activists) reached a consensus that La Mesa would promote the approval of the bill, as long as it safeguarded some aspects that were considered an ethical imperative, such as maintaining the ground of rape in the bill, which was the most contested of the three grounds.

Legal abortion on only three grounds: Confrontation over the limited scope of the reform

In January 2015, President Bachelet introduced a bill to liberalize abortion on three grounds: risk to the woman's life, fetal anomaly incompatible with life, and rape.

The legal reform took two and a half years of debate in Congress.[16] It represented a golden opportunity for those in favor of and those against abortion (including activists, social organizations, members of the medical community, religious organizations, and the like) to advance their arguments. For instance, the Health Committee of the Chamber of Deputies organized a two-day public hearing in September 2015 in which 89 people presented their arguments; of these, 20 were medical doctors, including 13 who were against abortion. The large majority of participants were individuals and organizations against the law reform.

The original bill suffered important amendments. The final text contained more restrictive regulations in several areas, including the definition of the grounds, time limits, and confidentiality, among others. Conscientious objection (CO) was one of the issues that experienced the most modifications during the legislative process and again (in the Constitutional Court) after it was passed, as will be discussed below.[17]

The bill was timid regarding the scope of the legal grounds; it never included risk to the pregnant woman's health, instead phrasing it as a "risk to

life," and during the debate this too was changed from "current and future life risk to life" to just "current risk to life." The ground of fetal anomaly incompatible with life was also very conservative, considering that most countries' abortion laws on fetal anomaly permit abortion for serious anomalies rather than fatal ones only.[17]

On the ground of rape, the upper time limits were reduced from 18 weeks to 14 weeks for girls under 14 years of age. It takes time for someone to be able to report rape, let alone seek an abortion. Furthermore, given the lack of expectation of pregnancy in a child, these reductions in the time limit were very serious restrictions.

With respect to confidentiality, the bill incorporated a human rights framework, upholding the rights to health and privacy by providing for the protection of women requesting a legal abortion and for those who experience health complications due to illegal abortion. In cases of risk to life and fetal anomalies, the general rule to keep medical records confidential, including the name of the patient, was applied. But in the case of women who request an abortion on the ground of rape, legislators eventually incorporated a provision requiring hospital directors to inform the Office of the Prosecutor whenever a woman requests an abortion due to rape, thus allowing the prosecutor to proceed with a criminal investigation. Women may well not wish this to happen, and they are supposedly not required to be part of the prosecution, but how this works out in practice remains to be seen. As a violation of confidentiality, however, it is very problematic.

In the case of illegal abortion, there are contradictory mandates regarding medical confidentiality for women seeking treatment when they experience complications. There are other contradictory mandates as well. While health care providers in both the private and public sectors must report women who have had an illegal abortion who seek care for complications, divulging confidential information received while on professional duty is considered a crime.[18] In the original bill, no woman who undergoes an illegal abortion could be reported, interrogated, or receive treatment contingent on the disclosure of information about her medical condition, or have her health status divulged. This provision was rejected, in complete disregard for international human rights standards and recommendations on the issue.[19]

Conscientious objection: From the exception to the general rule

In the original bill introduced by President Bachelet, CO was considered as permitted only for those health personnel who are directly involved in the abortion procedure: physicians. However, the public and legislative debate went far beyond that incorporating not only physicians but all health personnel directly involved.[20] This includes anesthetists, midwives, nurses, and nurses' aides. These workers must state their objection in writing, but there is no need for it to be substantiated.

After the Law was approved by the Congress in August 2017 a group of legislators filed a constitutional writ before Constitutional Court and prior to the enactment of the law. The Court in August 2017 allowed the recognition of institutional CO (Sentencia Rol N° 3729 (3751)-17 CPT, 28 de Agosto de 2017). The institutional objection was argued fervently by Catholic University during the legislative debate defending religious universities regarding the enforceability of the law for the provision of abortion services.

Even after all these substantive, and restrictive, changes and the passage of the bill in September 2017, there followed an 18-month-long administrative litigation on the regulation for health care services. Two protocols on CO were issued. The first one was changed 10 days after President Pinera took office. However the Office of the Comptroller General (Contraloría General de la República) ruled that the second protocol was unlawful because it had included institutional objection to private clinics that received public funding. A third regulation was published the 23th of October 2018. This opened for conservative legislators to take the matter to the Constitutional Court to rule on the scope and the basis for institutional objection. In January 2019, the court finally

settled the issue. The law as it now stands allows any private health institution to refrain from providing abortion services, based not only on religious or moral grounds but also on the right to association and the protection of the autonomy of private organizations and individuals.[21]

The court's ruling also permits private health institutions that provide gynecological and obstetric services at the primary and tertiary care level, including those that receive public funding, to invoke institutional conscientious objection. The constitutional basis for this ruling is the notion that, according to Chile's Constitution, private entities have visions or ideologies and hence must be respected. The court recognized the special status of Catholic hospitals due to the long tradition of health services in collaboration with the public health care system and the Catholic University is recognized by law in a special status. However, it went a step further by failing to make a distinction between confessional (Catholic) institutions and those that do not declare any type of religious ideology.[22]

So far, five institutions have registered to be exempt from complying with the law, and in one case a clinic declared an objection to providing abortion only on the rape ground. The Constitutional Court's ruling disregards the impact of its decision on women's right to health care. It states that institutional CO does not restrict women's rights to life or integrity because the objecting institution must provide an abortion when a woman's life is at risk, while for the other two grounds women can receive abortion care from a public health institution.[23] Despite recognition of CO abortion remains easily accessible in some countries, such as Portugal, England, and Norway, but in others like Italy CO is a stumbling block because many doctors use it.[24]

The implementation of the law: Monitoring progress from a feminist perspective

La Mesa and Fondo Alquimia invited six local organizations from the northern, central, and southern parts of the country to monitor the law's implementation in their geographical regions because it was a major concern of the feminist organizations. The idea was to identify practices and discourses that were either facilitating or hindering access to abortion in public health facilities.

Our qualitative research effort was carried out from September 2018 to February 2019. It involved 62 interviews with health care professionals who play a direct role in the law's implementation—namely, obstetrician-gynecologists, midwives, psychologists, and social workers. These individuals were working in a total of 15 primary care clinics and 8 hospitals with high-risk obstetric units. Additionally, 8 health care union representatives were interviewed, 7 focus groups with women were conducted, and 136 women were surveyed.[25] The interviews with the health personnel explored the training of health personnel and the existence of protocols and other instruments that guide, inform, assist and make referrals when needed in addition to the situation of sexual and reproductive rights in each territory.

Our survey was based on the premise that the implementation of any new health service is challenging and requires capacity building, staffing, training, regulations, workflows, infrastructure, and supplies. In the case of abortion in particular, it also involves dealing with a change in legal context (from prohibition and prosecution to partial legalization) and with deep-seated cultural and personal beliefs that cannot be expected to change overnight.

Our findings reveal that the disorientation that had characterized the early days following the law's passage has now been reduced. At first, health practitioners were trying to "catch up with the law," using trial and error to develop procedures for identifying those women entitled to a legal abortion and to ensure a smooth referral process. In some areas, this was even seen as an opportunity to strengthen the public health network. Moreover, in some places, health staff found that the use of the Ministry of Health's technical guidelines was an opportunity to improve service delivery, to positively contribute to women's psychosocial well-being in relation to reproductive loss and to provide social and psychological support for those women who have been raped.

We also found that there is an important

gap between written legal standards regarding information, confidentiality, privacy, and respect for women's decision making, and what actually happens in practice. The shortcomings seem to be associated with a mentality of "we cannot do much more," whereby health care personnel argue that there is no space for better infrastructure or systems. Such a response may be due to a lack of willingness to provide the services or fear of involvement. It seems to be consistent with our other finding that, in all of the locations studied, good implementation relies heavily on whether the *dupla* and the medical team involved in the provision of abortion are personally committed to overcoming the barriers.

Both declared and undeclared CO were an additional barrier that we identified. One gynecologist in a high-risk obstetric unit said that some health care staff avoided dealing with patients who might require an abortion: "'That patient does not exist for me, I'm an objector.'" Furthermore, some participants described situations in which indirect objection was manifested, such as by imposing additional requirements, particularly in cases of abortion requested on the ground of rape. "All kinds of barriers are put in place; for instance, the stuff required to be admitted at the hospital, like documents that must be signed... although it is not mandatory to sign them." Other interviewees said that some physicians did not respect the woman's right not to see or hear about the ultrasound examination: "They show them the scan and ultrasound forcing women to look at it, or they talk about god or things like that."

Access to information and legal abortion

In order to ensure the exercise of the right to a legal abortion, women's access to information is crucial. We found that women were not properly informed by the public health care system. Our interviews and focus groups revealed a lack of knowledge about when abortion is permissible and where to seek information and advice. This lack of information is particularly harmful for girls and women who are pregnant as a result of sexual violence and who have such a short time frame to get an abortion.

The Ministry of Health has not produced or made informational material available in health care facilities, and individuals must rely on the information posted on the ministry's website.[26] As of March 2019, when we completed our research, the only flyers and posters available to the public were those produced by local health personnel themselves, which had limited circulation.

The primary care system could potentially play a role in informing women, but there is an oversight of the Ministry of Health in addition to a lack of appropriate and effective guidelines on how and what to tell women about their health conditions and the possibilities for obtaining a legal abortion. Some participants said that there were a number of cases in which women were referred by midwives and physicians to the High Risk Obstetric Units without sufficient information. In some cases, midwives were explicitly instructed to withhold information from women regarding their health condition. One person reported, "Here [in the primary health care center] we all depend on what the doctor says, and the doctor did not inform the patient [on her condition]. I could not go over his authority, but I told the doctor that this patient was a candidate [for an abortion], but the doctor told me that we should not get involved but that he was going to make a referral to the high-risk obstetrics unit."[27]

In high-risk obstetrics units, where abortions are carried out, our research reveals that scarce information is provided to women about the techniques that may be used, whether surgical or with pills. In some cases, there is information available to women, but it is highly technical and not easily understood.

Training and protocols

In the six areas we studied, training for health personnel in primary care facilities and in high-risk obstetric units is limited to professionals who are directly involved in the abortion procedure, leaving aside other personnel who may also interact with women during the process.

In addition, the training implemented by the Ministry of Health has been restricted to technical aspects. In this respect, training should also incorporate value changes to reduce the prejudices and myths often associated with abortion, which are especially prevalent regarding women and rape. According to one member of a *dupla*, "We are questioned by physicians and other staff if the patient is making the story up, if it is true or not … They also ask us if the patient follows the accompaniment program, because if the woman does not, they argue she was lying."

Another problem arising from physicians' lack of training is the question of how to determine when the woman's life is at risk and whether the identified fetal anomalies are incompatible with life. Several interviewees described situations in which there were differing medical opinions on these questions among the team members who would perform the abortion and the non OB-GYN specialists who are consulted. The real issue here is that there is often uncertainty in medical assessments of this kind, differences of opinion are normal and it is unclear whether OB-GYN opinions are paramount. How to resolve them is problematic when the question is not about appropriate medical treatment but about whether the prerequisites of a legal abortion are met. One physician told us:

> *We had some disagreements with other colleagues … regarding a patient who had chronic renal failure … The risk of that patient's health deteriorating due to her pregnancy was very high. Nevertheless, the opinion of the nephrologists was that she could continue the pregnancy … It was a difficult case for everyone, because she fulfilled all the requirements, but the opinion of the internists opted for the continuation of the pregnancy. The patient's health condition worsened and finally she terminated the pregnancy … It was not an abortion; it was a premature birth, the newborn died anyway. But she could have been saved all that suffering for months of knowing what was going to happen.*

Our research indicates that obstetrician-gynecologists may not have the final word about the medical condition of a woman who needs and wants an abortion. According to the law, only one diagnosis is required for cases of risk to a woman's life. However, in practice, other specialists appear to get involved, making the diagnosis more cumbersome, especially if there are contradictory opinions on how to proceed.

Discussion

Legalization represents an important step forward, and many observers expected an active resistance by providers in complying with the law. As our survey reveals, the implementation of the abortion law has created serious challenges and stumbling blocks that prevent women from accessing legal abortions. This might be one of the explanations for the low number of women who have requested a legal abortion since the law's passage.

According to projections by the Ministry of Health, there should be 2,500–3,000 legal abortions per year, the majority (67%) of which are expected to be requested on the rape ground.[28] The actual numbers reveal another story. For the period September 2017– December 2018, the Ministry of Health reported 769 cases in which an abortion was permitted: 343 on the life ground, 311 on the fatal fetal anomaly ground, and 115 on the rape ground (in other words, only 15% of the total). It is possible that the difference between the ministry's initial estimates and the actual numbers might be due not to miscalculations by health authorities but rather to shortcomings in the implementation of the law.

This limited and limiting law does not guarantee autonomy or reproductive rights for girls and women. In fact, a medical opinion is required to certify any of the three legal grounds. Only once a woman overcomes this hurdle can she access an abortion—it restrains reproductive autonomy.

From a health care system perspective, moreover, it is highly questionable whether all abortions must be carried out in high-risk obstetric units. Abortion in the case of rape could be delivered in primary health settings via medical abortion pills, given that the time limit is 12 and 14 weeks; it would make the procedure more accessible considering the multiple factors (such as age, geographic location, and social class) that prevent women and girls

from reaching specialized obstetric units.

Access is also influenced by the level of information that women and girls have, impacting differently depending on their socioeconomic conditions, ethnic origin, disability among others. It possible that a lack of information is one of the reasons behind the currently low number of abortions requested on the rape ground.

Imposing time limits on teenage victims of rape or incest fails to consider the circumstances and the often challenging task of detecting early pregnancies. It is plausible that this restriction will make it impossible for girls to access legal abortions. Indeed, the data collected to date show that the rape ground is the least-cited ground for abortion requests, contradicting the Ministry of Health's initial estimates.

It is also possible that requiring hospital directors to file a report with the Office of the Prosecutor whenever a woman requests an abortion on the rape ground may discourage women from asking for help.

Allowing the wide use of CO has also created barriers, which was predicted from the outset. In fact, according to the most recent Ministry of Health report, the number of objectors has increased over time.[29] As of June 2019, one out of two obstetricians in public hospitals had declared themselves objectors in cases of rape (50.5%), one in four in cases of fatal fetal anomaly (28.6%), and one in five in case of risk to life (20.7%). For objectors in the case of rape, this represents a 5.3% increase compared to June 2018 data. Although there is no systematic information about what is happening, anecdotal evidence from physicians reveals that women are having problems accessing abortion as a result of individual and institutional objectors.

The refusal to provide abortion services has led to situations that significantly affect women's dignity and physical and mental integrity. Such scenarios even include the suspension of abortion procedures already underway.[30] On the positive side, committed providers, including physicians and midwives, have begun forming networks to help women overcome some of the barriers.[31]

The protocols are in place, but they are not being followed to the extent necessary to support the delivery of care under the conditions set out in the law. The current administration has an anti-abortion stance that shows little regard for informing women of their rights—it has been women's organizations that have been making efforts to conduct awareness-raising campaigns, trainings, and informational seminars aimed at increasing knowledge of where and under what circumstances women can get an abortion.[32] Likewise, legal actions have been taken to make the government compliant with the law.

Training health care providers on the content of the law and its regulations, building capacity among health care teams, and debunking myths and prejudices are essential to the delivery of care that is respectful of women's rights. Given the current context of increasing CO among health care providers, efforts will have to be made to hire staff who are supportive of women's need to access abortion. In some hospitals, health authorities cognizant of the problem have made calls to hire individuals who are committed to providing abortion care.

What's next? Some final thoughts

Chile's new abortion law represents a cultural change: abortion has come "out of the closet" and is finally being provided and discussed more openly. At the same time, the reform offers an opportunity to remove the social stigma around abortion, and women to continue to mobilize around reproductive autonomy.

The government, in addition to having a negative obligation to refrain from interfering with women's reproductive choices, also has positive obligations to provide financial and social support and to ensure that women's choices are effectively realized.

Unsurprisingly, the implementation of the law is still far from reaching that point. As our research shows, the restrictions established by the law itself, coupled with the lack of will to increase women's access to legal abortions, are important challenges.

Chile's new abortion law meets minimum state obligations concerning human dignity, in-

tegrity, and the right to health. However, its recent legalization of abortion, although an important advancement, is helping few women; it is crucial to move forward to remove the obstacles currently standing in the way of women's access. Here, there is an important role for women, feminists, and committed providers to play in dismantling practices and discourses in which women are foreordained to become mothers.

The limitations shown by our initial examination of the law's implementation must be considered in the context of a 40-year ban. Therefore, not only is it critical to train health care providers, but it is also necessary to foster a cultural change within the health profession that encourages respect for women's needs and rights. Any reform on abortion legislation is destined to encounter a range of problems—in order to move forward, we will must consider the best way to reduce the burdens and barriers created by the implementation of the new law.

References

1. Ministry of Health, *Norma técnica nacional de acompañamiento y de atención integral a la mujer que se encuentra en alguna de las tres causales que regula la ley 21.030* (Santiago: Government of Chile, 2018).

2. A. Del Campo, "El debate médico sobre el aborto en Chile en la década de 1930," in S. Zárate (ed), *Por la salud del cuerpo* (Santiago: Universidad Alberto Hurtado, 2008).

3. Ibid.

4. E. Gaviola, X. Jiles, L. Lopresti, and C. Rojas, Queremos votar en las próximas elecciones: Historia del movimiento femenino chileno 1913–1952 (Santiago: "Centro de Análisis y Difusión de la Condición de la Mujer, 1986).

5. E. Caffarena, "A las mujeres" (Santiago: Movimiento Pro-emancipación de las Mujeres de Chile, 1935). Available at http://www.memoriachilena.cl/archivos2/pdfs/MC0065896.pdf.

6. P. Jiles and C. Rojas, *De la miel a los implantes: Historia de las políticas de regulación de la fecundidad en Chile* (Santiago: Corporación de Salud y Políticas Sociales, 1992).

7. Monreal, "Factores determinantes del aborto ilegal en Chile," *Boletín Oficina Panamericana Sanitaria*, 86/3 (1979), p. 215.

8. Jiles and Rojas (see note 5); *Ley No. 18.826* (1989).

9. C. Bunch, "Historia y concepto de una movilización mundial," in C. Bunch, C. Hinojosa, and N. Reilly (eds), *Los derechos de las mujeres son derechos humanos: Crónica de una movilización mundial* (Mexico City: Rutgers and Edamex, 2000), p. 28.

10. G. Maira and C. Carrera, "Estrategias feministas para la despenalización del aborto en Chile: La experiencia de la Mesa Acción por el Aborto," in L. Casas and G. Maira (eds), *Aborto en tres causales en Chile: Lecturas del proceso de despenalización* (Santiago: Universidad Diego Portales, 2019).

11. Muñoz, "Morning-after decisions: Legal mobilization against emergency contraception in Chile," *Michigan Journal of Gender and Law* 21 (2014), pp. 123–175; G. Maira, "El pildorazo: Michelle Bachelet, nosotras y la defensa de la anticoncepción de emergencia," in A. Burotto and C. Torres (eds), *Y votamos por ella: Michelle Bachelet; miradas feministas* (Santiago: Fundación Instituto de la Mujer, 2010).

12. L. Casas and L. Vivaldi, "Abortion in Chile: The practice under a restrictive regime," *Reproductive Health Matters* 22/44 (2014), pp. 70–81.

13. C. Maturana, "Aborto: Derechos humanos de las mujeres frente al parlamento chileno," in Articulación Feminista por la Libertad de Decidir (ed), *Voces sobre el aborto: Ciudadanía de las mujeres, cuerpo y autonomía* (Santiago: AFLD, Escuela de Salud Pública "Dr. Salvador Allende G.," Facultad de Medicina, Universidad de Chile, 2014).

14. L. Casas, "La academia entre 'los seculares y lo confesionales': Las continuidades en la reforma por la despenalización del aborto en Chile y una historia personal," in L. Casas and G. Maira (eds), *Aborto en tres causales en Chile: Lecturas del proceso de despenalización* (Santiago: Universidad Diego Portales, 2019), p. 218.

15. Several accounts of this process could be found in L. Casas and G. Maira (eds), *Aborto en tres causales en Chile: Lecturas del proceso de despenalización* (Santiago: Universidad de Diego Portales, 2019).

16. Ibid.

17. R. Boland, "Second trimester abortion laws globally: Actuality, trends and recommendations," *Reproductive Health Matters* 18/36 (2010), pp. 67–89.

18. Criminal Procedure Code, arts. 175(d), 247.

19. Human Rights Committee, General Comment No. 28, The Equality of Rights Between Men and Women, (2000); Committee on Economic, Social and Cultural Rights, General Comment No. 22, The Right to Sexual and Reproductive Health, UN Doc. E/C.12/GC/22 (2016); Committee on the Elimination of Discrimination against Women, General Recommendation No. 24, Women and Health, (1999).

20. A full review of the debate can be found in R. Figueroa, "Objeción de conciencia en el fallo del tribunal constitucional sobre el proyecto de ley que despenaliza el aborto en tres causales," in L. Casas and G. Maira (eds), *Aborto en tres causales en Chile: Lecturas del proceso de despenalización* (Santiago: Universidad Diego Portales, 2019).

21. V. Undurraga, and M. Sadler, "The misrepresentation of conscientious objection as a new strategy of resistance to abortion decriminalisation," *Sexual and Reproductive*

Health Matters 27/2 (2019); J. M. Vivanco, "s" "La Objeción de conciencia como derecho constitucional" in L. Casas and D. Lawson (eds), *Debates y reflexiones en torno a la despenalización del aborto en Chile* (Santiago: Centro de Derechos Humanos, 2016) pp.179-229; M. Núñez, "Convicciones éticas institucionales y objeción de conciencia colectiva en el sector sanitario público y privado", Lidia Casas y Delfina Lawson (eds), *Debates y reflexiones en torno a la despenalización del aborto en Chile* (Santiago: Centro de Derechos Humanos, 2016) pp. 209-227.

22. Constitutional Court, Rol No. 3729 (August 28, 2017).

23. Constitutional Court, Rol No. 5572-12-CDS/5650-18 (collected) (January 18, 2019), para. 15.

24. W. Chavkin, L. Swerdlow, and J. Fifield, "Regulation of conscientious objection to abortion: An international comparative multiple-case study," *Health and Human Rights Journal* 19/1 (2017), pp. 55–68.

25. *Informe de monitoreo social: Implementación de la ley de interrupción del embarazo en tres causales* (Santiago: Mesa Acción por el Aborto y Fondo Alquimia, 2019). Available at http://accionaborto.cl/wp-content/uploads/2019/06/Informe-Monitoreo-Social-ley-IVE-Maach-Alquimia.pdf.

26. Ministerio de Salud, *Ley que despenaliza la interrupción voluntaria del embarazo en 3 causales* (January 3, 2018). Available at https://www.minsal.cl/todo-sobre-la-interrupcion-voluntaria-del-embarazo-en-tres-causales.

27. *Informe de monitoreo social* (see note 25), p. 31.

28. Biblioteca del Congreso Nacional, *Historia de la Ley 21.030*, Informe Comisión de Hacienda.

29. Ministerio de Salud, https://www.minsal.cl/funcionarios-objetores-de-conciencia-por-servicio-de-salud/.

30. Hospital de Quilpué será auditado tras falla en caso de mujer a quien negaron aborto por inviabilidad fetal," *El Desconcierto* (May 25, 2018). Available at https://www.eldesconcierto.cl/2018/05/03/hospital-de-quilpue-sera-auditado-tras-falla-en-caso-de-mujer-a-quien-negaron-aborto-por-inviabilidad-fetal/.

31. See https://www.facebook.com/redchilenadeprofesionales/ https://www.facebook.com/matrofemchile/.

32. *Ley 21.030*, art. 119 quáter.

Rights-based Claims Made by UK Anti-abortion Activists

PAM LOWE AND SARAH-JANE PAGE

Abstract

This article analyzes the ways in which rights-based arguments are utilized by anti-abortion activists in the UK. Drawing on an ethnographic study featuring 30 abortion clinic sites, anti-abortion marches, and other campaigns, we argue that rights-based claims form an important part of their arguments. In contrast to the way in which human rights law has been interpreted to support abortion provision, anti-abortion activists seek to undermine this connection through a number of mechanisms. First, they align their arguments with scientific discourse and attempt to downplay the religious motivation for their action. While this is an attempt to generate greater credibility for their campaign, ultimately, the coopting of scientific arguments actually becomes embedded in their religious practice, rather than being separate from it. Second, they reconfigure who should be awarded human rights, arguing not only that fetuses should be accorded human rights but also that providing abortion to women goes against women's human rights. This article is important in showing how rights claims are religiously reframed by anti-abortion activists and what the implications are regarding debates about access to abortion services in relation to religious rights and freedom of belief.

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Introduction

Across the UK, there has been a recent resurgence in anti-abortion activism outside abortion clinics, hospitals, and pregnancy advisory services. While the activities outside clinics have been happening for decades, more recently the number of people mobilizing against abortion has slightly increased and a greater number of clinics have been targeted.[1] Almost all of the activists are religiously motivated, with religious displays the most common type of activity outside clinics.[2] The difficulties experienced by those using services has led to campaigns for buffer zones surrounding clinics—areas free from activists—with the first one successfully being introduced outside a clinic in London in 2018. Despite the efforts of anti-abortion activists, support for abortion is strong in the UK, with more than 90% of people supporting access to abortion in at least some circumstances, and 70% advocating that it should be a choice for any reason.[3] Moreover, abortion is provided free for all those who are eligible within the National Health Service (NHS), accounting for approximately 98% of all abortions.[4]

This article investigates the relationship between anti-abortion activists' religious motivations and how they construct their views in relation to human rights discourses. First, we outline the general relationship between religion and rights-based discourses. Second, we demonstrate how data were gathered and how the findings were derived. Third, we outline how human rights claims and religious understandings are intertwined for UK anti-abortion activists. Lastly, we explore the implications for abortion rights claims if anti-abortion activism were understood as a specific religious practice.

As in other places, the UK is home to a range of anti-abortion organizations covering different activities. To name just a few: The Society for the Protection of Unborn Children (which claims to be the oldest anti-abortion organization in the world) was established in 1967 and focuses mainly on campaigning, political lobbying, and anti-abortion education. Life (which claims to have invented the term "pro-life") was set up in 1970 to provide crisis pregnancy services, and it also conducts anti-abortion education. The main organizations involved in anti-abortion clinic activism are Helpers of God's Precious Infants, the Good Counsel Network, the Centre for Bioethical Reform UK (often known as Abort 67), and, in Northern Ireland, Precious Life, although local groups also play an important role. In addition, some organizations take part in the biannual campaign 40 Days for Life, a US initiative that encourages local groups to stand outside abortion clinics for 12 hours a day for 40 consecutive days. Some of the organizations that target clinics, such as Precious Life, are also involved in other aspects, such as campaigning. The Alliance of Pro-Life Students provides support for a small network of university groups. Finally, March for Life UK is an annual event that seeks to bring together organizations and activists through running stalls, workshops, and a public demonstration.

Abortion, religion, and human rights

Increasingly, human rights law is being used to expand access to abortion.[5] Human rights bodies have successfully used arguments regarding women's equality and the rights to non-discrimination, health, autonomy, and liberty when advocating for the legalization of abortion, and many of these arguments have been upheld in national courtrooms and have contributed to progressive law reform.[6] This provides an important backdrop for current anti-abortion activities.[7] Indeed, the increasing use of a human rights framework by abortion rights advocates may have contributed to anti-abortion groups' efforts to refocus their own frames of resistance and utilize rights-based claims aimed at restricting abortion. Joshua Wilson argues, in relation to the ongoing legal arena in the United States, how both the movement and countermovement are shaped by the tactical turn of the other.[8] Once drawn into an arena, these movements develop capacity and expertise that then shapes future strategies.

The adoption of a human rights framing by anti-abortion groups builds on historic claims concerning the fetal right to life. While the first criminal statute was not passed in the UK until 1803, prior to this there were common law prohi-

bitions and legal cases involving prosecutions for abortion.[9] As John Keown has shown, during this history, there was some debate about the point at which the fetus was recognized as having legal protection, and there were considerable difficulties in distinguishing between abortion and other fetal losses, which meant that there was uncertainty over the issue.[10] Nevertheless, some cases were brought against women and others, such as the prosecution of Margaret Webb for consuming poison with the intention of "destroying" a fetus in her womb in 1602.[11] The common law position is likely to have built on earlier understandings from ecclesiastical courts, and thus religious beliefs were important in the formation of ideas about abortion, centered on the notion of ensoulment—that is, the point at which a fetus acquires a soul. Historically, quickening—the moment at which the fetus can be felt moving—was often taken to be a marker of ensoulment; terminating a pregnancy before quickening was not usually deemed problematic, while doing so after this point was.[12]

The right to life of the fetus was a significant issue in the debates during the passing of the 1967 Abortion Act, and it has continued to be an important point for those opposed to abortion. However, the medical framing of the abortion law means that attempts to restrict abortion have often not followed this line of reasoning.[13] Since 1967, the attempts by anti-abortion groups and politicians have focused on, in their terms, reducing "abuses" and introducing other measures to restrict abortion. With one exception, all legal attempts to restrict abortion since the 1967 Abortion Act have failed.[14] The only successful legal change, which happened in 1990, reduced the time limit for most abortions from 28 to 24 weeks; but at the same time, it clarified and extended the exceptional grounds for when abortions could take place at any time. This change did not significantly restrict services, as most later abortions were carried out for reasons covered by the exceptional grounds. While anti-abortion activists have not been successful in changing the law or reducing services, their constant attempts to restrict access and demonize service providers contribute to the ongoing stigmatization of abortion.[15]

Anti-abortion activists have long recognized that framing their opposition around religious objectives alone would not necessarily be a successful strategy. When the Society for the Protection of Unborn Children was established, it made a specific decision to be "secular" and to not have leaders who were Catholic, in order to tactically distance the organization from its religious roots.[16] More recently, the public materials (for example, leaflets and website) of the Centre for Bioethical Reform UK make no direct references to religion, even if the majority of staff and volunteers are religiously motivated and one of the organization's projects focuses specifically on encouraging churches to advocate against abortion. Hence, while religious belief has long been at the heart of the anti-abortion movement, anti-abortion groups have a long history of adopting "secular" frames to promote their arguments.

The number of people in the UK who describe themselves as religious is declining, and recent research has found that more than half of the population now states that it has no religion.[17] Yet while fewer people are religious, those who are, Grace Davie suggests, take their religion more seriously.[18] The majority of religious practitioners accept or support abortion in similar numbers to those without faith.[19] However, anti-abortion activists are typically highly religious Christians, with the majority being Roman Catholic.[20] Linda Woodhead specifies that 8.5% of the religious landscape in Britain is constituted as a "moral minority, typified by high levels of religiosity and deep conservatism on sexuality issues."[21] It is also important to note that while there is widespread tolerance of religion across the UK, it is tolerated only to the extent that it is low key and unobtrusive.[22] In general terms, public displays of faith are frowned on, save for specific occasions such as Christmas, and even then, they are often more acceptable if they are understood as ecumenical and potentially even having a non-faith dimension.[23] This prevailing attitude toward religions and religious practices means that many anti-abortion activities are considered to fall outside of generally accepted behavior on the basis of their faith-based public practice and

their opposition to abortion. The lack of general support—among both those with a faith and those with none—to restrict abortion highlights the difficulties that anti-abortion groups face when seeking to frame their arguments.

Methodology

This article emerges from an ethnography of abortion debates in UK public spaces, which focused on public activism, especially around abortion clinics. Over a five-year period, we carried out observations at 30 clinic sites targeted by anti-abortion groups in a variety of large and small cities and towns. We visited many of the abortion clinics more than once, and our observations usually lasted between one and two hours. During observations, we took fieldwork notes on the geography, signs, and behavior of the anti-abortion activists and, when present, abortion rights groups' counter-actions. We also took photographs of the activism, taking care not to photograph clinic users or staff. The notes and photographs that were taken during ethnographic encounters were later written up into formal research accounts.

In some places, organizations such as the Good Counsel Network are directly involved in organizing a clinic presence, whereas in other cases, organizations provide the necessary support for local grassroots groups to begin and sustain clinic activism (for example, Helpers of God's Precious Infants). Across the UK, those taking part in clinic-based anti-abortion activities are overwhelmingly Roman Catholic, with a minority being Evangelical Christians. During the course of our fieldwork, we encountered only a few individuals who were not aligned with one or another religious tradition. Some sites have more than one group taking action, and individuals can be active in more than one group, which makes it difficult to ascertain who is "leading" the activities on any particular occasion. Typically, there will be two to four anti-abortion activists present, with larger groups of 30–50 on special occasions. The largest group we observed consisted of approximately 160 people outside a hospital in Glasgow in April 2019. Many of the groups have signs and religious iconography. At some sites, these elements are present throughout the activity, but in other places, individuals bring their own "displays" and remove them when their shift finishes.

Apart from sites organized by the Centre for Bioethical Reform UK, the anti-abortion activists were usually praying, either silently (often using rosary beads to pray the Rosary) or audibly in unison with others, occasionally singing hymns. On many occasions, direct approaches to women seeking abortion services would be made by "pavement counselors." Whether or not direct approaches were made was related to the specific site and to the particular anti-abortion activists present. On hospital sites, for example, approaches were not usually made because the anti-abortion activists frequently had to stand outside the hospital grounds, meaning they could not easily identify those seeking abortion services. Most activists made individual decisions regarding what they actually did, such as whether to directly approach service users. This individual-based style also meant that the type of activism varied hour by hour, as those present at any given moment determined the form of activism. Some sites had activists present on a daily basis, whereas others had people present only for a few hours a week, or only during the 40 Days campaign. Moreover, even if anti-abortion groups signed on to the 40 Days campaign, the commitment to being present for 12 hours a day for the full 40 days was fulfilled only by a minority, demonstrating the challenges that anti-abortion activists face in achieving broader support.

We also conducted formal and informal interviews with a range of activists who provided their consent. Some interviews were conducted at the site of activism and varied in length from 10 minutes to nearly an hour. Other interviews were formally arranged away from the activism site, usually in a quiet café or the home of the participant. These interviews were normally recorded, centered on specific topics, and lasted as long as two hours. Both formal and informal interviews were designed to enable participants to raise points of interest and to explain their activism in their own words and

at length. Due to the small numbers of anti-abortion activists in many locations, we cannot include demographic information, as this could potentially identify our participants and thus breach their confidentiality. In certain situations, we are also unable to provide details of the exact location of the activism, as this too would compromise confidentiality.

The dataset consisted of field notes from observations and informal interviews, transcriptions of formal interviews, and photographs. We also collected and analyzed materials such as leaflets that were being distributed at activist sites, focusing on both the written content and any accompanying drawings or photographs. In addition, we attended public anti-abortion events, including five annual "March for Life" events (three in Birmingham and two in London) and accompanying counter-demonstrations. We also gathered data at local government meetings, particularly in relation to the buffer zone debate. Finally, we added documents containing public statements made by activist groups to the data set, focusing on key moments such as council debates on buffer zones. The analysis of all textual data (such as transcripts, field notes, and documents) followed the thematic analysis principles of Virginia Braun and Victoria Clarke.[24] Initial coding was generated following close reading of the data, and these were then combined into broader themes. The photographs were used to add depth to the field notes, but also analyzed in relation to the themes emerging in the textual data. This article arises from the human rights theme, which contained data on when abortion needed to be stopped on the basis of rights-based claims.

Ethical approval was granted by Aston University. Ethical issues emerging throughout data collection centered on our position as researchers and on negotiating access to individuals suspicious or hostile toward our motivations. We wore university identification during fieldwork and highlighted our role as university researchers. Some activists robustly declined to speak to us; others wanted us to speak to the vigil or other organizational leaders instead of them. In our exchanges with participants, we tried to frame our interactions as an open inquiry, using a conversational style. Some groups had previously encountered hostile press coverage, creating concerns regarding our intentions. We stressed the academic nature of our investigation, as well as the importance of generating a range of views on the issue so that we could report on the activism as accurately and fully as possible. As both of us take a pro-choice stance, difficulties sometimes emerged when we were directly questioned regarding our own views on abortion, but we were always open about this and stressed that in the context of data collection, the activists' views were more important than ours. Some took this as an opportunity to explain more fully their motivations for activism.

Findings

"It's not just about religion"

Despite the majority of anti-abortion activities outside of abortion clinics having a religious component, many of the activists stated that religion was not necessarily their main motivation for being there. For example, one of the activists during a Lent 40 Days campaign outside of a clinic in central London in 2019 told us that she had been involved in anti-abortion activism for a number of years and also supported prayer vigils run by the Good Counsel Network. On that particular day, she was covering an early morning shift and was holding her rosary beads and reciting prayers with others. Next to her, propped up against the fence, was a candle, flowers, and a picture of Our Lady of Fatima, producing an altar-like display on the pavement (Figure 1). She explained that she had brought the items from her home. Yet despite both this individual religious framing and the overarching rationale of the 40 Days campaign to "pray to end abortion," she stated that her opposition to abortion "wasn't just about religion." This sentiment was repeated frequently by those engaged in religious activities outside clinics:

> *Even if I wasn't religious I would still be really concerned to protect unborn children. (interview, Nottingham, 2017)*

> *But for me, the bit that becomes more black and*

> *white philosophically is either you believe life starts with conception or you don't. And if it's not a baby … if it's not a life, what is it? … I come at it probably less from a faith-based point of view and more from a philosophical point of view. (interview, Birmingham, 2016)*

We suggest that framing their activism as being beyond religion is not simply a denial of the importance of their faith; rather, it indicates how everyday faith practices can be inclusive of other frameworks. As a form of lived religion—that is, how individuals themselves negotiate their religious practices—the anti-abortion activists interpret and shape religious doctrine into individualized beliefs and practices.[25] Moreover, as we will show below, this includes potentially adopting "secular" understandings into their religious practices. In other words, while the activists themselves may suggest that their adoption of a "rights" or "equality" framework is separate from their religious motivations, the way that they engage and articulate these ideas demonstrates that they are shaped by their religious practice.

FIGURE 1. Pavement display in London, 2019

Source: Photo taken by the authors

Unique "losses"

Generally speaking, the activists outside of abortion clinics accepted a "life from conception" position in which abortions should not take place under any circumstance. This position, for a few, stretched to denying that abortion was ever needed to save a woman's life. For example:

> *Interviewer: But some women have to have abortions or they will die themselves?*
>
> *Activist: I don't know about that [doubtful tone, long pause]. Ireland has the highest, the most safest place to have a baby was Ireland, then they brought in abortion, because there is money to be made. (field notes, London, 2019)*

The belief that the absence of abortion made Ireland safer was rooted in an understanding that abortion is an "unnatural" act and that abortion service providers are motivated by profit.[26] In addition, on two recent occasions (Cheltenham 2019 and London 2018), we were told that it was "not true" that Savita Halappanavar's death in Ireland in 2012 was due to the constitutional ban of abortion in place at the time, although the official report concerning her death indicated that her health care team did not offer best clinical practice because of concerns about the legal status of abortion.[27] Understanding the activists' position is made more complex by the doctrine of double effect, which states if the intention is good, an act is moral even if it has a bad outcome. This means that treating a woman for a life-threatening condition is permitted even if it causes the fetus to die, provided that the main "intention" is treatment rather than terminating the pregnancy. Using this premise, anti-abortion organizations have argued that it was not law but medical negligence that led to Halappanavar's death. However, during our interviews, it was not clear if individuals specifically accepted the double-effect doctrine or if they simply accepted the overall messages from anti-abortion organizations that her death had nothing to do with the law.

From the activists' "life from conception"

position emerged an understanding that each fetus was a "unique" human being, and this was rooted in the adoption of scientific claims. They frequently mentioned that science "proved" that life began at conception, stating that each fetus has "individual DNA." Examples include the following:

> *[I]t is not just a woman's body, we are carriers when we carry children. It is in our body, our body, but it is a completely separate living entity with its own human DNA, its own bloodstream. (field notes, March for Life, 2016).*

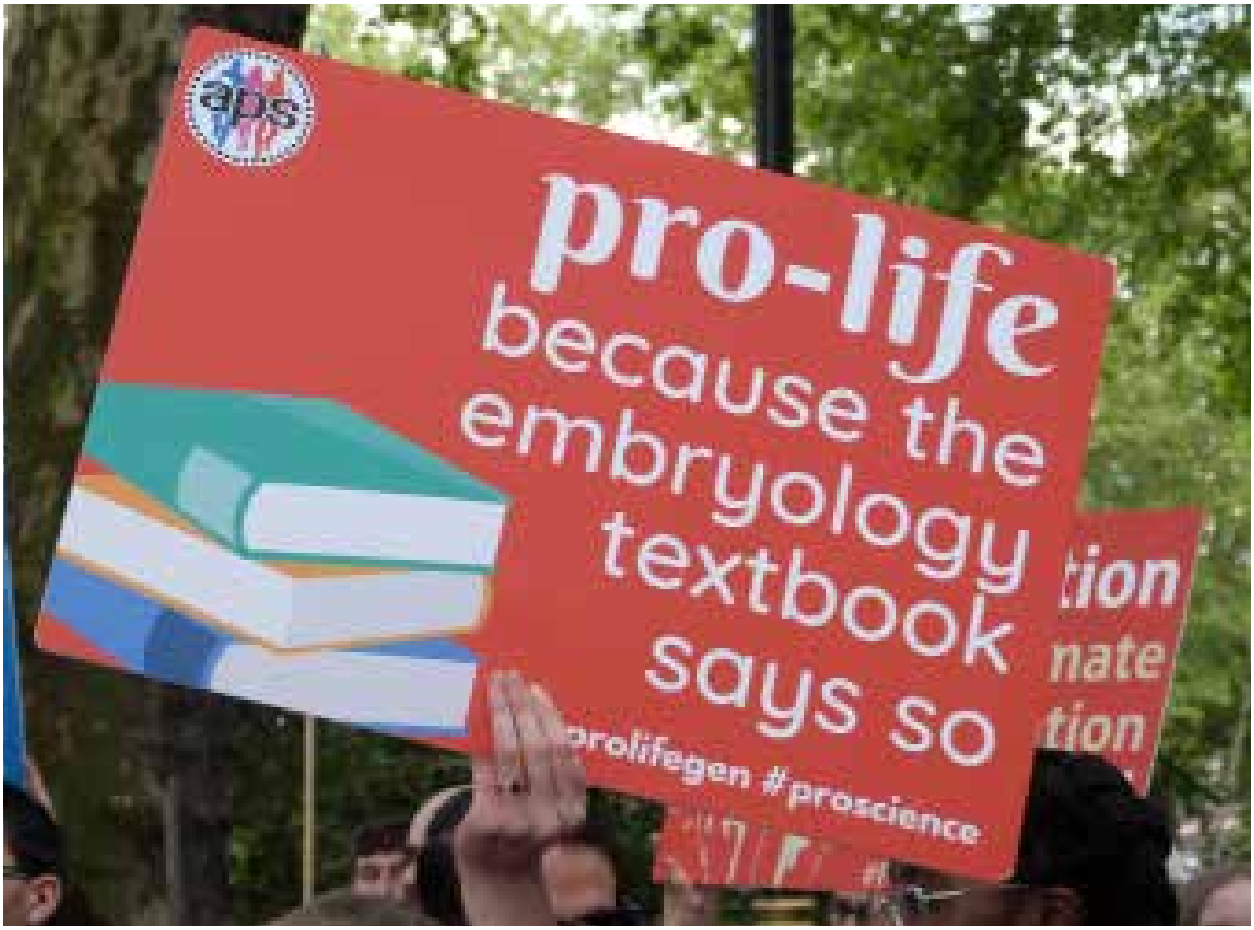
> *You realize that your [pro-abortion] view is going against science, the science of conception? (field notes, London, 2016)*

One activist, who spoke passionately about religious teaching on abortion, sought to bring together claims about science, rights, and the relationship between mother and developing fetus by talking about equality. She argued that DNA proved that the fetus was human; and as a human, it has a right to equality, which was jeopardized by the promotion of abortion:

> *Age is an artificial construct. If we look at what is human, especially about biology … if it has human DNA and meets the test of being alive, it is human life and has a right to its own equality … They both have equality … The argument that abortion is anyway a promotion of equality is wrong, it promotes inequality between mother and child. That inequality exists, but not to the degree that you say the child has no rights. (interview, Midlands, 2018)*

Some organizations go further in adopting "science" as the foundation from which "rights" may

FIGURE 2. Alliance of Pro-Life Students sign during the March for Life, London, 2019



Source: Photo taken by the authors

be claimed on behalf of the fetus. For instance, the Abort 67 website (now taken down) featured quotations from medical textbooks that discussed embryology and genetics, which the organization felt supported its claim that "science" determines when life begins. We observed this sentiment among members of the Alliance of Pro-Life Students, who had a number of placards at the 2019 March for Life making scientifically focused rights-based claims, including the phrase "Pro-life because the embryology textbook says so" (Figure 2). In this case, neither the sign nor the activist holding it referred to a specific book. On the one hand, utilizing scientific authority could be a means through which activists seek to appeal to a secular audience unconvinced by religious reasoning for opposing abortion. But on the other, such secular messages appeared indivisible from activists' everyday religious framework, according to which every child was a "gift" from God and choosing to have an abortion was thus denying God's will. This understanding was often underscored by reference to a Bible quote from Jeremiah 1:5 in public displays: "Before I formed you in the womb I knew you."

In short, anti-abortion activists' foundation position is premised on a religious belief in which each pregnancy is a "gift", and therefore abortion is contrary to God's intentions. From this understanding, they interpret and incorporate ideas from "scientific" discourse into their everyday anti-abortion religious practices.

"Missing people"

The Vatican has utilized rights-based frameworks to endorse conservative notions of rights, such as the right to life, and this positioning can be located in Catholic discourse more broadly, particularly within anti-abortion narratives.[28] The foundation position is that a "unique" life has been created. From there, the assignment of "rights" is, for the anti-abortion activists, a logical progression, and the number of abortions undertaken is then discursively positioned as "missing" people. For example, on the 50th anniversary of the UK's Abortion Act, the *Catholic Herald* published an article entitled "The Bill That Wiped Out Millions." The article described abortion as the "industrial destruction of human life," noting that "the sanctity of human life has been thrown into open trash bins."[29]

Given that the *Catholic Herald* is a religiously mediated periodical, the term "sanctity of life" clearly embraces a religious meaning, and it represents an idea counter to the "industrial," which connotes large-scale, and possibly even polluting, levels of abortions. The fetal right to life given by God is "destroyed" by the secular world. This also came up in discussions with activists; one participant in Glasgow explained the importance of allowing everyone to be born, linking this to a personal story in which his grandmother had been left for dead at birth, but a health care professional had realized at the last moment that she was alive. He attached significance to the fact her own generational line had produced many children, who had all offered key service roles to the community in the health care professions and charity work, thereby underscoring the important contribution they had made.

Claims about equality and the right to life also allow the anti-abortion activists to make comparisons to historical situations featuring a denial of rights, such as slavery and the Holocaust. As one activist explained:

> *When people saw slavery, they had to put an end to it. When people see abortion, if they are convicted they will have to put an end to it. So I see it in the same level. There are people without rights, who need to be stood up for. It is exactly the same thing, it is no less. (interview, Birmingham, 2016, emphasis added)*

The use of the term *conviction* in this quotation is important. As a theological idea, it means that God is encouraging one to change one's behavior and therefore live a righteous path. In this case, it means that taking a stand against abortion becomes a demonstration of one's sacred commitments to God.[30] This quotation thus not only aligns the campaign against abortion with the campaign against slavery, but does so with a specific religious understanding. In both cases, human rights (the right of the slave and the right of the fetus) are understood as being revoked. The power of aligning the issue of

abortion with slavery lies in a more universal understanding of slavery as an inherently bad thing, thereby appealing to more secular sensibilities—if one is against the evil of slavery, then one must also be against the "evil" of abortion. This position of aligning the two together is sacredly endorsed through the understanding that fighting them is a religious commitment. For the activists, changing the minds of others to oppose abortion becomes rooted in the very raison d'être of their religiosity, as this quotation indicates:

> *I don't want Him [God], when I breathe my last breath … to say, "But what did you do about it?" I just go down to the abortion clinic, to satisfy my conscience really. I'm doing what I can. I could probably do more, actually, but at least I'm doing something. (interview, town south of England, 2017)*

Therefore, by taking a stand, one is doing God's work. This then causes tensions with those Catholics (the majority) who do not participate in anti-abortion activism. The activists saw this as problematic, and it was not uncommon for them to criticize others of faith and faith leaders for a lack of active participation in their campaign.

Reworking women's rights

As we have described elsewhere, for the anti-abortion activists, womanhood and motherhood are religiously entwined. The activists therefore believe that abortion is always a result of pressure or coercion, as women would never "naturally" choose abortion.[31] Positioning the fetus as a bearer of rights attracts the common refrain that women's right to bodily autonomy is subsequently eroded. This was addressed by activists in a number of ways. One strategy was to reconstitute women's rights into responsibilities (in the quotation below, the activist used "child" in the context of an abortion being considered):

> *Mothers and children are active in stages of development throughout that whole process. But not at the degree of development which you say the child has no rights. The responsibility of any adult towards a child during the development of the child from start to finish is one of protection and support. It's not one of power. (interview, Nottingham, 2017)*

In this way, when fetal rights are recognized, a woman's rights are not overtly revoked but rather reworked in relation to her "unborn child." There is slippage here in how the woman is addressed; calling the woman considering an abortion a "mother" is no accident. A woman's role is inherently bound up with motherhood in these accounts, and abortion is seen as a threat to this "natural" inclination. Women have a "right" to be mothers. In addition, invoking the woman as a mother from the moment she conceives ensures that the particular expectations of maternal sacrifice are invoked, making the responsibilitization narrative more plausible.[32] This was also supported in signs we saw at activist sites with slogans such as "Value motherhood, choose life," accompanied by an image of a woman kissing a baby (Edinburgh, 2017).

The understanding that motherhood is both natural and under threat frequently underpinned activists' claims that abortion is harmful. For example, at one public demonstration in Nottingham, participants held placards saying "Abortion kills babies and hurts women" and "Women deserve better than abortion." In this way, abortion is framed as being inherently harmful to women and as a form of rights violation. One participant at another anti-abortion event said:

> *[A]s a woman myself, I am all for equal rights for empowering women and I think it is quite sad in a way that a lot of feminists fight so hard for abortion when the original feminist like Alice Paul described abortion as the ultimate exploitation of women. I don't think abortion empowers women; I think it puts them in a horrible situation, a horrible position. (March for Life, 2016)*

For this participant, and many others, motherhood is women's role, meaning that abortion undermines women's main purpose in life and thus their authentic selves. Consequently, abortion is seen as fundamentally anti-feminist, going against equal gender rights. In such discussions, abortion due to rape is also seen

as fundamentally harmful to women:

> *Rape isn't necessarily, to me, a reason to have an abortion. The baby hasn't done anything wrong. The man has done something wrong who has raped … But why should the baby be punished by being killed? Then the mother's body, in a way, is violated twice. First of all she's raped and then a baby is ripped out of her. (interview, town south of England, 2017)*

In such cases, women's rights were understood as being affirmed through taking an anti-abortion stance.

Discussion

> *It's hard to fight increasingly obvious science … This is why we are seeing a renewed crackdown on pro-life protests: they … represent the very inconvenient truth … A movement that thinks nothing of the very right to life can hardly be expected to cherish the right to free speech for its opponents.*[33]

This quotation is taken from an anti-abortion article in the *Catholic Herald* opposing the imposition of buffer zones around abortion clinics. It illustrates two themes we have analyzed within the rights-based claims of anti-abortion groups: their incorporation of science into their claims and their belief that support for abortion involves ignoring or destroying rights, including the rights of women themselves.

Despite their strong reliance on religious iconography and practices, many of the activists sought to downplay their religious motivations, stating that their opposition to abortion is based on understandings of human rights and equality rather than on religious teachings. In other words, they explained that they would actively oppose abortion regardless of whether they were religious. The explicit utilization of secular-based equality and human rights claims, we argue, cannot be understood simplistically as a strategic choice aimed at appealing to a secular audience. Instead, it should be understood as being adopted and incorporated into activists' very religious practice. Indeed, while science and religion have often been considered as two oppositional frameworks, our findings demonstrate the way that the secular and the religious become entwined.[34] Nonetheless, the way that these two elements are woven together is complex.[35]

Focusing on the everyday lived practices of religion reveals the ways in which individuals are active in constructing religious meanings in their lives.[36] As Meredith McGuire argues, the experiences of individuals of faith are different from the beliefs that are defined at an institutional level, and in everyday practice, individuals incorporate and disregard official teachings in various ways.[37] In other words, for people of faith, involvement in the anti-abortion movement needs to be understood as a central element of their religious practice, and this is also likely to be important in the way that they understand themselves as religious people. Opposing abortion is a means of demonstrating their religious identity, even though their active opposition to abortion places them within a religious minority.

The use of science and other secular narratives within anti-abortion campaigns has often been documented as arising from a religious position.[38] We argue here that the relationship between secular frames and religious beliefs of the anti-abortion movement is complex. As our analysis shows, "secular" understandings of the "science" of conception appear to be reshaped and used as part of anti-abortion activists' lived practice of religion. The idea of the "unique" person—identified though individual DNA—is easily interpreted within their understanding of each fetus being an individual gift from God. While they are comfortable with the use of a science frame to promote a belief in life from conception as an "obvious truth," our analysis suggests that the activists may not necessarily recognize that this understanding is informed by and incorporated into their religious practice. Understanding religion as a lived practice that allows a "flexible" pathway of belief enables the incorporation of scientific "facts" such as the uniqueness of DNA to be read through a religious lens. Research in other areas has shown how potentially challenging scientific ideas can be coopted rather than rejected.[39] Religious practice is (re)interpreted and (re)constructed in relation to issues that are

particularly pertinent to a specific faith position.[40] However, the religious (re)interpretation of the science of DNA may not have had the universal appeal that anti-abortion groups are hoping for.

We have demonstrated elsewhere that activists' opposition to abortion is rooted in essentialized constructions of womanhood in which motherhood is the only "natural" role for women, based on conservative religious understandings of separate spheres and gender complementarity.[41] This understanding shapes their actions, regardless of whether they choose a religious approach or adopt more "secular" scientific messages.[42] Their religious ideas, such as regarding women's "natural role" as mothers, form an important part of their opposition to abortion.[43] In relation to rights claims, the activists work these ideas into a position where abortion itself poses a threat to women's rights, even in cases such as rape, and where abortion is seen as never being really medically necessary. This challenges the positioning of abortion as a woman's fundamental human right, as advocated by human rights bodies.

Our findings add an important new dimension to the ways in which the rights claims of anti-abortion groups are understood. While the narratives used by those opposed to abortion may adopt the secular language of rights claims, their arguments do not simply build on their religious beliefs—instead, they constitute those very religious beliefs. This is also illustrated in their rejection of the term "protest" in favor of "prayer vigil" to describe their activities outside abortion clinics.[44] Recognizing anti-abortion views as a religious practice rather than just a religious strategy raises both challenges and opportunities. The right to hold individual religious beliefs is, and should be, supported, which raises questions about the extent to which there should be attempts to change anti-abortion views. However, as articulated in *Dulgheriu & Anor v. The London Borough of Ealing* (2018), a case centering on a legal challenge to the UK's first buffer zone, freedom of belief is a qualified right that can be curtailed to protect the freedom of others.[45] The key point of this judgment is that while activists have a right to hold anti-abortion views, this right should not extend to being able to constrain abortion or intervening when women are accessing abortion services. There is an important distinction between the holding of individual beliefs and appropriate ways to demonstrate and try to convert others. The space outside service providers is not seen as an appropriate space for anti-abortion religious practices. Recognizing anti-abortion activism as a religious practice, and thus an individual belief, could therefore actually encourage the protection and enhancement of abortion access by fostering recognition that there is both sacred and secular pluralism and that the beliefs of some should not curtail the rights of others.

References

1. P. Lowe and G. Hayes, "Anti-abortion clinic activism, civil inattention and the problem of gendered harassment," *Sociology* 53/2 (2019), pp. 330–346.
2. P. Lowe, and S-J. Page, "'On the wet side of the womb': The construction of mothers in anti-abortion activism in England and Wales," *European Journal of Women's Studies* 26/2 (2019), pp. 165–180.
3. K. Swales and E. A. Taylor, *British social attitudes 34* (London: National Centre for Social Research, 2017).
4. Department of Health and Social Care, *Abortion statistics, England and Wales: 2017* (2018).
5. R. Rebouché, "Abortion rights as human rights," *Social and Legal Studies* 25/6 (2016), pp. 765–782.
6. Ibid.
7. B. Baird, "Decriminalization and women's access to abortion in Australia," *Health and Human Rights* 18/1 (2017), pp. 197–208.
8. J. C. Wilson, *The street politics of abortion: Speech, violence, and America's culture wars* (Stanford Law Books, 2013)
9. J. Keown, *Abortion, doctors and the law: Some aspects of the legal regulation of abortion in England from 1803 to 1982* (Cambridge: Cambridge University Press, 1988).
10. Ibid.
11. Ibid.
12. Ibid.
13. F. Amery, "Solving the 'woman problem' in British abortion politics: A contextualised account," *British Journal of Politics and International Relations* 17/4 (2015), pp. 551–567.
14. Ibid.
15. E. Lee, S. Sheldon, and J. Macvarish, "The 1967 Abortion Act fifty years on: Abortion, medical authority

and the law revisited," *Social Science and Medicine* 212 (2018), pp. 26–32.

16. K. Hindell and M. Simms, *Abortion law reformed* (London: Peter Owen, 1971).

17. Swales and Taylor (see note 3).

18. G. Davie, *Religion in Britain: A persistent paradox* (Chichester: Wiley-Blackwell, 2015).

19. Swales and Taylor (see note 3).

20. Lowe and Page (see note 2).

21. L. Woodhead, *Religion and personal life* (London: Darton, Longman and Todd, 2013).

22. Davie (see note 18).

23. M. Engelk, "Angels in Swindon: Public religion and ambient faith in England," *American Ethnologist* 39/1 (2012), pp. 155–170.

24. V. Braun and V. Clarke, "Using thematic analysis in psychology," *Qualitative Research in Psychology* 3/2 (2006), pp. 77–101.

25. M. McGuire, *Lived religion: Faith and practice in everyday life* (Oxford: Oxford University Press, 2008).

26. Lowe and Page (see note 2).

27. Health Service Executive, *Investigation of incident 50278 from time of patient's self referral to hospital on the 21st of October 2012 to the patient's death on the 28th of October, 2012* (2013).

28. L. M. Morgan, "Reproductive rights or reproductive justice? Lessons from Argentina," *Health and Human Rights Journal* 17/1 (2015), pp. 136–147.

29. D. Alton, "The bill that wiped out millions," *Catholic Herald* (October 27, 2017), p. 20.

30. S. F. Harding, "Convicted by the holy spirit: The rhetoric of fundamental Baptist conversion," *American Ethnologist* 14/1 (1987), pp. 167–181.

31. Lowe and Page (see note 2).

32. Ibid.

33. E. Condon, "Public enemies?," *Catholic Herald* (January 19, 2018), p. 21.

34. D. Martin and R. Catto, "The religious and the secular," in L. Woodhead and R. Catto (eds), *Religion and change in modern Britain* (London: Routledge, 2012).

35. E. Butler, "God is in the data: Epistemologies of knowledge at the creation museum," *Ethnos* 75/3 (2010), pp. 229–251.

36. McGuire (see note 25).

37. Ibid.

38. D. Wyatt and K. Hughes, "When discourse defies belief: Anti-abortionists in contemporary Australia," *Journal of Sociology* 45/3 (2009), pp. 235–253.

39. Butler (see note 35).

40. McGuire (see note 25).

41. Lowe and Page (see note 2).

42. Ibid.

43. Ibid.

44. Lowe and Hayes (see note 1).

45. *Dulgheriu & Anor v. The London Borough of Ealing* [2018] EWHC 1667 (Admin) (02 July 2018). Available at http://www.bailii.org/ew/cases/EWHC/Admin/2018/1667.html.

Midwives and Post-abortion Care in Gabon: "Things have really changed"

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Abstract

Complications from spontaneous and induced abortion are a primary cause of death of women in sub-Saharan Africa. Le Réseau d'Afrique Centrale pour la Santé Reproductive des Femmes: Gabon, Cameroun, Guinée Équatoriale (the Middle African Network for Women's Reproductive Health, or GCG as it is commonly known) was founded in 2009 to identify and overcome obstacles to post-abortion care in Gabon. Research identified the main obstacle as lack of emergency skills and provisions among first-line health care providers. To fill the lacuna, GCG designed a program to train midwives in manual vacuum aspiration (MVA), misoprostol protocols, and the insertion of T-shaped copper IUDs. This article presents a nine-year retrospective (2009–2018) of the program. Qualitative and quantitative results confirm correlations between midwives' practice of MVA in health centers and spectacular decreases in treatment delays, with corresponding decreases in mortality from abortion complications. Our findings also demonstrate how these advances have been threatened by opposition to midwife practice in certain urban medical centers despite encouragement by the Gabon Ministry of Health to use the new protocols. Women's human right to the highest attainable standard of health, including access to safe abortion, is an assumption that GCG shares with the 40 African countries that have ratified the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. The training program illustrates how a direct-action strategy can fully equip medical practitioners, especially those in peripheral sites with meager resources, to provide emergency post-abortion and abortion care even before governments legislate their human rights commitment.

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Introduction

More than half of pregnancy-related deaths of women globally occur in sub-Saharan Africa. Among those deaths, complications from unsafe abortion are one of the most common and easily preventable and treatable causes.[1] By "abortion," we refer to spontaneous, induced, or missed abortions, as well as a multitude of other conditions requiring the evacuation of uterine products, such as intrauterine fetal demise and molar pregnancy.

In Gabon, the legal prohibition of induced abortion has not deterred women from ending unwanted pregnancies. The risk of criminal sanctions has, however, obliged them to do so without medical assistance until complications arise. The fact that incomplete induced abortion often presents the same symptoms and requires the same treatment as spontaneous or unviable pregnancies renders any woman with early pregnancy distress suspicious and thus susceptible to interrogation, reprimand, and mistreatment by medical personnel.

This article describes the strategy developed from 2009 to 2018 by a local network in Middle Africa for assuring quality emergency care for women with abortion complications. We begin by describing the socio-juridical context of our research site, Gabon, followed by an account of our field needs assessment, training process, quantitative and qualitative evaluation studies, and ongoing challenges. The quantitative studies that serve to demonstrate the statistical impact of training have already been published, albeit without discussion of the training process itself. We briefly summarize the experiments and the intervention modalities behind the reported results. Our qualitative interview study, published here for the first time, gives voice to midwives as emergency medical practitioners and inside witnesses within hospital wards. Whereas the quantitative studies verify our advances and setbacks in one hospital setting from 2009 to 2018, the qualitative study explains those dynamics through an analysis of interviews with 20 midwives and 12 doctors practicing in diverse rural and urban settings, all of whom participated in training over the same nine-year period. At the end of the article, we discuss our method in the context of the global movement for safe abortion. Rather than put forth a human rights discourse in the hope of persuading governments to provide adequate abortion provisions for women in line with their ratification of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (better known as the Maputo Protocol), we presume those rights and network directly with frontline emergency health care providers in dire need of enhanced clinical tools.

Background: High-risk abortions and inadequate treatment of complications

In 1969, contraceptives were outlawed in Gabon, and their sale was strictly prohibited (Law 64/69). Only in 2000 was the prohibition lifted and an explicit right to contraception decreed under a set of general measures for the health of women and children (Law 2000). Since that time, women have been allowed, if not encouraged, to delay childbearing. But 10 years later, modern methods still represented only 11.5% of contraceptive use, with women relying primarily on abortion to regulate their fertility.[2] For abortions, plants with abortive properties are the traditional method of choice. Adolescent girls learn to use such plants as a discrete, if risky, strategy to abort a pregnancy at no cost and in hiding from their parents.[3] Older women likewise rely on such methods to space or limit births.[4] The most commonly used methods are the insertion of a plant stem into the uterus or the ingestion of plant-based purging substances such as herbal teas and vaginal washes with lemon, ndolé, papaya root, grass, manioc leaves, papaya leaves, ginger, permanganate, bleach, salt, or quinine. In a GCG study of obstacles to post-abortion care, 60% of women interviewed about their own or a friend's self-induced abortion reported success without complication and 40% reported some sort of complication. The frequent success stories encourage others to try the same; meanwhile, common accounts of complications range from successful but traumatic resolution with the help of a traditional therapist, pharmacist, or doctor to lifelong disability to tragic death.[5]

In 2018, women interviewed for a study on contraceptive use in the north of Gabon made frequent reference to their use of the abortifacient medication misoprostol (often referred to by its brand name Cytotec).[6] Alongside traditional products, Cytotec has entered the popular vernacular of parlors, streets, and markets; it is available for little money from local merchants, accommodating pharmacists, and some physicians. Although far better than plant methods, misoprostol abortions do still need back-up medical help in cases of incomplete expulsions or complications due to poor-quality drugs, overdoses or underdoses, or pre-existing conditions.[7]

In Western Europe, abortion-related mortality and morbidity are described as "negligible" by the World Health Organization.[8] In contrast, complications from unsafe abortion in Middle Africa are among the main causes of pregnancy-related death. One in eighty-five women of reproductive age risks dying in her lifetime from pregnancy-related complications in Gabon.[9] Anecdotally, as soon as we speak of abortion, we hear accounts such as "A girl died in my village last week" and "Everyone in Gabon knows at least one woman who died from abortion complications."

The Middle Africa Network: Founding and networking

Le Réseau d'Afrique Centrale pour la Santé Reproductive des Femmes: Gabon, Cameroun, Guinée Équatoriale (the Middle Africa Network for Women's Reproductive Health, or GCG) was founded by two social science research activists, Aimée Patricia Ndembi Ndembi from Gabon and Gail Pheterson from France, the former just having completed a study on contraception in her country and the latter having developed a model for improving access to safe abortion in the Caribbean.[10] They invited Gabon-based midwife Justine Mekuí and South African-based physician and abortion expert Marijke Alblas to join them in adapting the Caribbean Initiative on Abortion and Contraception to the Middle Africa context. The Caribbean initiative had been conceived in 2001 to investigate abortion practice in a sub-region of the Caribbean with frequent travel between islands whose laws range from strict prohibition to elective first- and second-trimester abortion. Networking with health care providers and feminists, researchers found active abortion practices—both within and outside the law—among health professionals, who confidentially expressed the need for improved skills and provisions. Beginning on five small islands of the Northeast Caribbean and extending throughout the region, project directors organized regional and cross-regional workshops and conferences on manual vacuum aspiration (MVA), misoprostol protocols, and contraception. Those trainings mobilized a network of practitioners and feminists from 14 Caribbean countries who came together in Antigua in 2005 for educational sessions and to draft a declaration of health professionals, scientists, and advocates for the decriminalization of abortion in the Caribbean.[11] At present, the initiative is networking with the Solidarité Fanm Ayisyen (Solidarity of Haitian Feminists) to train Haitian physicians and nurses working in rural and urban zones.

The main goal of GCG is to prevent avoidable deaths and disability among women due to pregnancy-related complications. In line with the Caribbean initiative, we began our process in peripheral low-resource sites and went from there to the closest emergency medical centers. We launched the project in 2009 in Bitam, a small town in the north of Gabon near the southern border of Cameroon and the eastern border of Equatorial Guinea. National borders in this region are a colonial artifact separating one people, the Fang, who share a language, customs, and material needs.

After 10 days of visits to every health facility in the cross-border environs of Bitam, we brought together nearly all medical personnel on the Gabon side of the border—about 40 practitioners in total—along with leading midwives from nearby towns in Cameroon and Equatorial Guinea. Participants expounded on the main health risks of pregnancy, namely infection, hemorrhage, hypertension, and severe anemia, which are often compounded by conditions such as HIV, malaria, tuberculosis, and

diabetes. They enumerated the lacunas in material conditions, including light, water, electricity, sterile gloves, stethoscopes, telephones, transportation, incubators, oxygen, a blood bank, and contraceptives. In addition, they bemoaned the obstacles faced by women in accessing services (stemming from a lack of money and transportation), together with those that they, as service providers, faced in administering emergency care (due to inadequate equipment and skills). They expressed relief at the presence of an international team led by someone from their own community (midwife Mekuí was born in Bitam and speaks Fang) for the purpose of improving service delivery. We knew that although we could not resolve the infrastructural needs, we could improve the emergency care that was currently being offered.

Our next stop was the medical center in Oyem, the provincial capital one hour from Bitam. There, we met Rosalie Ndoutoume, the only ob-gyn specialist for the entire northernmost province of Gabon, Woleu-Ntem, who quickly agreed to our conducting midwife trainings at her hospital. We proceeded to Libreville, the country's capital located nine hours away, where we met with the National Association of Midwives and ob-gyn specialists at the public hospitals, all of whom agreed to join our network. The standard medical practice both in Libreville and in Oyem for treating abortion complications was dilation and curettage under general anesthesia. Our new ob-gyn physician allies, also researchers, knew (in line with World Health Organization guidelines) that MVA under local anesthesia was a safer, faster, and less expensive method, thus their receptivity to our initiative.[12] They would become close collaborators in gathering hospital data for charting the impact of our work. In addition to their in-house support, they assisted us behind the scenes, such as by using their authority at the airport customs office to retrieve GCG materials sent from Europe or by passing on to us international donations of MVA equipment that they had in stock.

Upon hearing about our project, one of the new physician specialists in our network shared with us his recently completed study (from 2009) of comparative delays in emergency treatment at the largest public hospital in Libreville. The mean time between emergency room admission and treatment for women who died from post-partum hemorrhage or eclampsia was 1.2 hours, while it was 23.7 hours for women who died from abortion-related complications. He and his researcher colleagues concluded that discrimination against women who had induced an abortion increased their risk of dying.[13] This correlation between abortion stigma and poor medical treatment has been documented elsewhere in Africa and throughout the world.[14] But even with efforts to eradicate stigma, patient overloads in obstetrical emergency wards undermine optimal care by requiring a ranking of emergencies, however dubious the criteria. In addition to challenging the stigma of abortion, our goal was to increase the efficiency of emergency services such that all patients could receive timely quality care.

The trainings, 2010 to the present

Within 18 months of our August 2009 field trip, GCG had conducted clinical workshops in eight rural and urban sites in Gabon, Cameroon, and Equatorial Guinea on MVA, misoprostol protocols, and the insertion of T-shaped copper IUDs.[15] Hands-on clinical training was limited since we could not predict—and thus schedule—treatment for pregnancy-related complications. The Caribbean Initiative on Abortion and Contraception had given us a model for addressing training challenges in countries with restrictive abortion laws: we identified those practitioners best placed and most motivated to themselves become local trainers and, after on-site preliminary workshops, organized intensive trainings for these practitioners in a foreign country with legal abortion and high caseloads. We found a partner in Tunis, where abortion has long been legal, who agreed to help us conduct such intensive training in May 2011. Although we have been unable to replicate that workshop as of yet, we were able to reinforce the training at home through a series of workshops conducted by Marijke Alblas, our expert consultant. Within two years, GCG's local medical coordinator, Justine Mekuí, was herself

a regional trainer.

Since its launch in 2009, GCG has trained more than 500 hospital practitioners in Gabon, mostly midwives, in MVA. Although less than half of the trained midwives actually practice regularly, they all support and are familiar with the method, thus reinforcing acceptance of MVA as a tool for midwives, as well as physicians, to resolve abortion-related complications. An unanticipated factor in facilitating the spread of improved emergency care is the frequent transfer of midwives from one medical facility to another, both in rural and urban zones. They bring their materials with them to new settings, where they train midwife and physician colleagues.

Evaluation of the trainings and change in practice

Quantitative outcomes

Three of the Tunis trainees—two midwives and one ob-gyn specialist—worked as a team at the hospital site where the aforementioned study on comparative delays in emergency care was conducted. That study provided us with a before-training measure.[16] Within months of returning from Tunis, the team succeeded in making MVA the standard procedure for post-abortion care. Once the new protocol was in place, our GCG research associates again gathered data on delays in treatment and published the following results: whereas before the training 100% of emergency complications were treated with dilation and curettage by ob-gyn specialists accompanied by an anesthesiologist, after training two-thirds of complications were treated immediately upon arrival at the hospital with MVA and local anesthesia, half by midwives and the other half by the Tunis-qualified ob-gyn physician or his colleagues (who had been trained on the job). Before the Tunis training, the mean delay in the treatment of incomplete abortions was 18 hours (23.7 hours for those who died); after training, the mean delay decreased to 1.8 hours.[17] Charting mortalities up until 2013, rapid emergency care—half of which was provided by midwives—effectively lowered the percentage of pregnancy-related deaths due to abortion complications from 10% (2008-2010) to 2% (2011-2013).[18]

In 2013, this research hospital appointed a new administrator who prohibited midwives from practicing MVA. Investigators continued to chart delays in treatment and to correlate them with mortality statistics. From 2014 to 2016, delays in treatment increased, and death from abortion complications rose from 2% to 14.1% of all pregnancy-related deaths.[19] Without midwives practicing MVA, the ob-gyn specialists prioritized women with serious complications requiring an operating theater, general anesthesia, and lengthy interventions such as Caesarean sections or hysterectomies. Meanwhile, women with initially minor problems, notably incomplete abortions, were once again left waiting for hours in hospital corridors. Physicians used MVA for rapid out-patient procedures when they found the time. But the delays were far greater than when midwives, now idle at the side of women in crisis, had intervened immediately.

Qualitative analyses of improvements and setbacks

The team heard, anecdotally, that sentiments among medical personnel in the hospital corridors shifted from exasperation with women patients for having induced an abortion to exasperation with rigid medical administrators for prohibiting competent health professionals from exercising their life-saving skills. However, the Ministry of Health supported GCG in its training of midwives as emergency practitioners of MVA. Yolande Vierin, the ministry's national director of maternal and child health, called on GCG to "train all the midwives of Gabon." But hierarchies within medical establishments are sometimes more determinant of medical protocol than governmental stances, especially given the ministry's reticence to speak publicly about abortion. One rigid hospital administrator cannot prevent national trainings, on-site trainings in rural and urban settings, or midwives using their skills when they can, regardless of authorization. But arbitrary hierarchical obstacles can undermine the quality of care at a particular medical facility, with grave consequences for women.

Our qualitative study conducted among

practitioners in diverse rural and urban medical facilities gives an overview of midwives' experience. In 2017–2018, two of this paper's authors—GCG's medical coordinator (Mekuí) and its president (Ndembi Ndembi)—conducted semi-structured interviews with 20 midwives trained in MVA and unstructured interviews with 12 physicians (7 ob-gyn specialists and 5 general practitioners). This research had the support of the Centre National de la Recherche Scientifique et Technologique, where Ndembi Ndembi holds a research post. Half of the midwives and all of the physicians were interviewed on the job (where they could refer to caseload registers); the other half of midwives were interviewed in Lambaréné and Koulamoutou during the Annual Conference of the Gabon Midwife Association, where GCG conducts an annual day-long workshop. Public hospitals were the main work site of these interviewees, although practitioners also use their skills in private medical facilities since they often hold multiple posts inside and outside the public sphere.

Our interview guide for midwives focused on the nature of abortion emergencies and treatment outcomes with MVA; training and practice in diverse settings; doctors' attitudes toward midwives' enhanced authority; midwives' degree of satisfaction with the method; their feelings about abortion; and their opinions about the country's restrictive law. Our unstructured interviews with physicians focused on an opening inquiry of "How is it going with midwife MVA practice in the emergency ward?"

For an indicative sample of abortion emergencies, we asked 2 of the 20 midwives to detail the nature of the problems they treated with MVA at a particular site over a specified stretch of time. For one midwife at the Centre Hospitalier Universitaire de Libreville, between March 2015 and April 2018, 26 of 39 (67%) of the emergencies she treated with MVA were due to incomplete self-induced abortions, 6 (15%) were due to intrauterine embryonic demise, 4 (10%) were due to incomplete miscarriage, and 3 (8%) were due to an undeveloped embryo. All pregnancies were between 6 and 12 weeks. For another at the Centre Hospitalier Régional de Port-Gentil, between July 2018 and January 2019, 8 of 13 (61%) were due to incomplete induced abortions under 12 weeks' gestation, 3 (23%) were due to intrauterine embryonic demise under 13 weeks' gestation, 1 (8%) was due to partial infected expulsion of a multiple pregnancy at 14 weeks, and 1 (8%) was due to retention of the placenta after delivery. As to outcomes, neither those two midwives nor the others we interviewed had had any complications. Turning to our interviews, we will now present the issues that were discussed, as structured by the interview guide.

Training occurs both on the job and in national workshops. One midwife said, "When I first arrived [for a new position at an urban hospital], I didn't know how to do it. Then a colleague [midwife] taught me and then I participated in a training." And another explained, "I was trained by the gynecologist. I've been doing it now for two months. I'm in the province of Haut Ogooué [rural zone]. It has really changed things." And a physician said, "I train midwives, I need their help. I've got cases from the whole province night and day. I'm overwhelmed."

Although training occurs in both rural and urban settings, the situations are not comparable. For midwives in rural zones, MVA has been crucial in equipping them to treat women unable to travel the distance to find an ob-gyn specialist. For example, the Health Center of Kango is 100 kilometers from Libreville, and the road is so bad that it can take more than two hours to reach the capital, not to mention prohibitive transportation costs. Although there is a general practitioner on the premises in Kango, it is the midwife, more expert in pregnancy matters than the generalist, who handles abortion complications. In other rural towns, such as Mabanda and Ndindi, there is neither a doctor nor a midwife; the GCG-trained birth attendant performs MVA. In Oyem, the northern rural provincial center, the specialist declared, "Since midwives are doing MVA, I can sleep in peace. From time to time, I give a look, everything is going well, there hasn't ever been a problem. Midwives do it really well." Likewise, in Tchibanga, the southern provincial base, a physician urges midwives from surrounding rural sites to come to his hospital for training: "We [ob-gyn specialists] will accompany

them [midwives and nurses] for a time, we won't immediately give them the aspirators. Then, after sufficient practice, they can do it."

In contrast, in urban areas, cooperation between health professionals is not always so congenial. Midwives recounted their worst experiences: "I never had the occasion to use it [the MVA kit], the doctor confiscated the syringes." "The interns made war with us midwives over this affair of MVA. I was called into the office of my superior several times." "He [ob-gyn head of service] told me, 'You, the *sage* [literally "wise woman"], I hope the day that it goes badly you'll know how to open the belly.'" This last quotation reveals physicians' occasional sarcastic mockery of midwives, with an underlying assumption that post-abortion care is above their capacity. In fact, numerous studies demonstrate that the clinical outcomes of midwife MVA performance are equal to those of physicians.[20]

Sometimes, as demonstrated above, MVA practice depends on the authority of a particular, often transitory, hospital administrator. Midwives keep one another informed about the services available at their medical facility and refer patients accordingly: "I was trained by a [midwife] colleague, but I send the ladies to the CHUL [public hospital in Libreville] because I'm not allowed to do it in my establishment for the moment." Aside from the occasional interference of administrators or physicians, midwives sometimes hesitate to practice MVA until they feel fully confident. One admitted, "I was trained but I haven't yet practiced. It takes courage. I worry I'll make a mistake with the para-cervical block." Another said, "We midwives take more care than most doctors to ease women's pain and fear."

Overall, also in urban settings, midwives and doctors work together so emergency patients do not experience long delays before treatment. In Libreville and Port-Gentil, for example, where hospitals' patient load is immense, midwife-led emergency care frees obstetrical surgeons for major surgeries in the operating theater. One midwife noted, "I've been practicing MVA for the past six years. I've saved many lives. Sometimes the doctor is busy. MVA is really good." Another said, "Here it's me who handles incomplete abortions with MVA, it's so practical." And another said, "It's the gynecologists themselves who send me their patients."

As for general satisfaction with the method throughout the country, whether in rural or urban zones, midwives and doctors expressed relief and pride in treatment improvements through MVA. One rural doctor said, "When midwives are trained, their work is fantastic. They save lives." And a midwife noted, "I'm very satisfied with this practice. Things have really changed." The phrases "I/They save lives" and "Things have really changed" were repeated again and again in the interviews.

Officially, GCG training in MVA is geared to post-abortion care, and the network speaks little about primary abortion provision. During our interviews, we nonetheless asked midwives to share their feelings about abortion and Gabon's restrictive law. Whereas feelings about abortion ranged from a sense of tragedy to moral judgment to resigned acceptance, opinions about the law were unambivalently in favor of decriminalization. Here's a sample of contrasting feelings: "My niece died after an abortion." "It's a bad thing, of course, as a Christian it's difficult." "I lost several patients, it's revolting." "I think one has to help adolescents." "Abortion isn't good but it's a fact, there's no family planning education." "No matter what, clandestine abortion is an everyday affair. What to do? We have to save lives!"

Regarding the law, opinions expressed in the interviews proved to be representative of a consensus at the yearly conference attended by hundreds of midwives—namely, unanimous denunciation of the juridical prohibition of abortion: "We should change the law, too much is too much, we're living an hypocrisy." "Things have to evolve." "The law is dangerous." "We should reconsider the law." "This law is obsolete." "Thank goodness the law is not respected!"

T-shaped copper IUD, misoprostol, and community education

Our primary focus in this article has been MVA. GCG's trainings, however, also include contracep-

tion sessions with hands-on workshops on how to insert copper IUDs, information on misoprostol protocols for primary and post-abortion care, and consciousness-raising sessions to lower abortion stigma. These trainings run parallel to GCG's community education efforts.

With regard to contraception, we focus on easy access, low cost, long-term effectiveness, minimal inconvenience and likelihood of complication, and ease of insertion and removal. The T-shaped copper IUD fits these criteria, and longitudinal studies conducted by GCG demonstrate women's satisfaction with the method.[21] With regard to misoprostol protocols, we rely on World Health Organization guidelines.[22] For consciousness-raising and stigma reduction, a sharing of experiences in discussion groups and pedagogic conferences on abortion realities in the world help normalize, and thus destigmatize, abortion.

Educational sessions in towns, villages, and high schools on sexuality, contraception, abortion and access to health care are meanwhile ongoing. Women and girls of four generations participate in village meetings. High school principals invite GCG coordinators and medical experts to talk to students. Midwives often co-facilitate meetings and serve as future resource persons. Our answers to the questions raised depend on the reality of quality contraception and post-abortion services in the community. Without those provisions and services, education in low-resource settings frequently turns into warnings and reprimands levied against sexually active women and girls rather than occasions for transmitting information and facilitating access to services.

Discussion: Political strategies and clinical methods

Worldwide, many groups focus on decriminalizing abortion as a necessary condition for women's access to safe services. This legal approach has experienced long-awaited successes, as well as excruciating setbacks. Others focus on mifepristone-misoprostol abortion through on-site or online grassroots provision of the drugs delivered with good information. That global mobilization testifies to the struggle to achieve safe, accessible abortion without professional support or government permission. Both the top-down legal approach to institutional services and the grassroots drug approach to home abortions are vital. There is room and need for multiple tactics in this thorny battle.

The strategy we have presented here is a cross between the institutional and grassroots approach. We are convinced that women need and deserve institutional services provided by well-qualified and well-equipped professionals, especially when faced with life-threatening pregnancy complications. While we advocate for the decriminalization of abortion, we know that services cannot await legal reform; we also know that a good law does not assure accessible services. Our experience tells us that joining forces with well-placed allies within the system is a faster and often more fruitful strategy for change than working with large governmental or nongovernmental organizations for whom grants and ministry approval must precede actions. We find the quiet, direct mobilization of on-site health providers more engaging and more sustainable. The midwives in our network are public health forerunners. They favor legal reform but do not await it to express collective solidarity as health professionals with women: "Thank goodness the law is not respected."

We understand that many abortion rights activists in the world are functioning in places where dying from pregnancy-related causes, other than unsafe abortion, is rare. That is not our situation. We are also aware that home abortions have been taboo in many places until the introduction of misoprostol. In Middle Africa, home abortions have long been the cultural norm, as have home therapies of many kinds; modern medical aid is traditionally more a last resort in case of emergency than a routine support for the healthy. Seeking help after an abortion, whether performed by oneself or a traditional practitioner, fits into the overall pattern of "aftercare," especially for pregnant women. In fact, post-abortion care is the norm for women everywhere if one includes spontaneous abortion, miscarriage, or other organic abortion events; those scenarios are

so common that women often take the precaution to reside near a medical facility during their pregnancy and often wait to announce their pregnancy until after the third month of gestation.

Access to misoprostol has been as revolutionary for women as was access to contraception. Home abortions in Middle Africa with misoprostol (even without mifepristone, the ideal partner drug) are safer than they have ever been; they do, however, still require back-up emergency care in case of complication. Repeated doses of misoprostol may, or may not, resolve incomplete or otherwise ill-turned home abortions. Like all clinical methods, efficacy depends on both physical and social realities. Women in our context do not rush to a medical facility when they see the first signs of complication. They wait, hoping their condition will improve so they can avoid parental scolding, public shaming, or legal sanction, not to mention costs beyond their means and frightful medical intervention. Only when their condition deteriorates badly do they decide to seek help, and then they must still find transportation money and await a bus, boat, or car. By the time they arrive at the hospital, they may have been bleeding for days. Treating a woman at this point with misoprostol does not make sense. The woman needs immediate treatment, not administration of a drug requiring medical surveillance at the hospital. Usually there are no beds available, and, regardless, women dread hospital admittance due to the social exposure and expense. MVA is the most secure and responsible medical response. It is a 10-minute procedure, whereas with misoprostol women must wait hours or days, and aspiration may still be necessary. So clinically, materially, socially, and financially, MVA is the preferable method for the rapid, safe, and effective resolution of post-abortion complications.

Within our context, focusing on follow-up treatment for the full range of induced and spontaneous abortions was realistic, critical, and legally irreproachable since attending to medical emergencies is a professional obligation under all legal regimes. Of course, we know that the tools and skills for post-abortion care are identical to those for inducing an abortion, and we trust midwives and doctors to use their new competence on women's behalf. We disregarded the colonial Napoleonic criminal code that prohibited abortion in Gabon, as in many former colonies of France, since it is irrational, unjust, and life-threatening.[23] We stand by the 40 African states, including Gabon, Cameroon, and Equatorial Guinea, that have signed and ratified the Maputo Protocol recognizing women's right to safe abortion. Like most signatory states, the three countries in our network had not yet legislated their commitment to justice for women when we designed our project. Rather than engage in a tug-of-war with governments, we prioritized strategies that make an immediate difference to women.

In 2019, GCG organized multiple public encounters with health authorities to announce its research findings and discuss obstacles to safe abortion services within the health establishment. As this article goes to press, we are pleased to learn that Gabon legislators have revised the Penal Code to allow abortion in the first trimester of pregnancy for minors in distress and for adults when there is grave fetal deformity, when the pregnancy is the result of rape or incest, and when the pregnant woman's health would be seriously jeopardized by continuation of the pregnancy.[24] We hope to participate in implementing and extending the reform and in facilitating access to primary abortion care as soon as possible.

Conclusion

Looking back at nine years of GCG activism, we see concrete improvements in women's access to post-abortion care. The network has clearly enhanced emergency services in numerous rural and urban sites. The work ahead remains vast, however, in Gabon and, even more so, across the borders. Our greatest success has been mobilizing, training, and legitimizing midwives. This ongoing process has the full support of rural physicians and health administrators. In urban medical facilities, certain physicians resist midwife authority, but most express satisfaction with the significant advantages of teamwork with their midwife colleagues.

Certainly, we hope that by implementing

women's right to the highest attainable standard of health, we will eventually undermine archaic colonial constraints. In Fang culture, there is a tradition of women disobeying the chief's orders to introduce a spirit called Évus. This spirit brings intelligence, knowledge, and determination into the community to "*rend toutes choses possible*" ("make all things possible").[25] GCG midwives ride their own wisdom as they work together to make sex and pregnancy possible for women without trauma, coercion, disability, or death. The crux of our struggle is neither legal nor clinical nor economic, but rather political. Subordination of women is the problem. Respect for women as patients, health care providers, and independent human beings is our essential drug and invaluable instrument for change.

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References

1. World Health Organization, *Maternal mortality (2018). Available at https://www.who.int/news-room/fact-sheets/detail/maternal-mortality.*

2. S. Chiesa-Moutandou and G. Tiemeni Wantou, "Le comportement contraceptif des Gabonaises les méthodes modernes: Faible taux d'utilisation et déficit d'information," *Médecine d'Afrique Noire* 48/5 (2001), pp. 191–198.

3. A. Retel-Laurentin, *Un pays à la derive: Une société en régression démographique; Les Nzakara de l'Est centrafricain* (Paris: Jean-Pierre Delarge, Collection Encyclopédie Universitaire, 1979).

4. A. P. Ndembi Ndembi, *Contraception et désir d'enfant: Approche psychologique et culturelles de la sexualité des femmes gabonaises* (Sarrebruck, Germany: Éditions Universitaires Européennes, 2007).

5. I. Moundaka, *Obstacles à l'accès aux soins d'urgences suite aux complications des avortements non sécurisés dans la province du Moyen Ogooué au Gabon: Aspects juridique, socioculturel et médical, sociology doctoral thesis, Université de Paris (2014).*

6. A. P. Ndembi Ndembi, "L'impact du DIU: Une étude exploratoire sur le vécu de femmes Gabonaises vivant à Bitam dans le nord du Gabon," *Revue Ivoirienne des Sciences du Langage et de la Communication* (2018), pp. 251–266.

7. World Health Organization, *Clinical practice handbook for safe abortion* (Geneva: World Health Organization, 2014); A. P. Ndembi Ndembi (2018, see note 6).

8. World Health Organization, *Unsafe abortion: Global*

and regional estimates of incidence of unsafe abortion and associated mortality in 2008, 6th ed. (Geneva: World Health Organization, 2011).

9. N. Kassebaum, et al., "Global, regional, and national levels and causes of maternal mortality during 1990–2013: A systematic analysis for the Global Burden of Disease Study 2013," *Lancet* 384 (2014), p. 993.

10. A. P. Ndembi Ndembi (2007, see note 4); G. Pheterson and Y. Azize, "Abortion practice in the Northeast Caribbean: 'Just write down stomach pain'," *Reproductive Health Matters* 1/26 (2005), pp. 44–53; G. Pheterson and Y. Azize, "Avortement sécurisé hors la loi dans le Nord-Est des Caraïbes," *Sociétés Contemporaines* 61 (2006), pp. 19–40.

11. G. Pheterson and Y. Azize Vargas, "Safe (illegal) abortion in the North-East Caribbean" (December 8, 2015). Declaration available at https://pole-suds.site.ined.fr/fichier/s_rubrique/23165/caribbean.initiative.pp.dec2015.ined.fr.pdf (slide 40).

12. World Health Organization, *Safe abortion: Technical and policy guidance for health systems (Geneva: World Health Organization, 2012), p. 2.*

13. S. Mayi-Tsonga, N. I. Litochenko Oksana, T. Thierno Diallo, et al., "Delay in the provision of adequate care to women who died from abortion-related complications in the principal maternity hospital of Gabon," *Reproductive Health Matters* 17/34 (2009), pp. 65–70.

14. E. K. Yegon, P. M. Kabanya, E. Echoka, et al., "Understanding abortion-related stigma and incidence of unsafe abortion: Experiences from community members in Machakos and Trans Nzoia counties Kenya," *Pan African Medical Journal* 24 (2016), pp. 1–9; A. Kumar, L. Hessini, and E. Mitchell, "Conceptualising abortion stigma," *Culture, Health and Sexuality* 11/6 (2009), pp. 625–639.

15. M. Alblas, *Needs assessment among health care practitioners, training sessions across regional borders and train-the-trainer program in pregnancy prevention and post-abortion care* (Amsterdam: Rutgers and World Population Foundation, 2013).

16. Mayi-Tsonga et al. (see note 13).

17. S. Mayi-Tsonga, P. Assoumou, B. Sima Olé, et al., "The contribution of research results to dramatic improvements in post-abortion care: Centre Hospitalier de Libreville, Gabon," *Reproductive Health Matters* 20/40 (2012), pp. 16–21.

18. U. Minkobame, S. Mayi-Tsonga, P. Assoumou Obiang, et al., "Transient reduction in abortion-related deaths after interventions to reduce delays in provision of care at Centre Hospitalier de Libreville, Gabon," *International Journal of Gynecology and Obstetrics* 143 (2018), pp. 247–248.

19. Ibid.

20. See M. Klingberg-Allvin, A. Cleeve, S. Atuhairwe, et al., "Comparison of treatment of incomplete abortion with misoprostol by physicians and midwives at district level in Uganda: A randomised controlled equivalence trial," *Lancet* 385/9985 (2015), pp. 2392–2398; I. K. Warriner, O. Meirik, M. Hoffman, et al., "Rates of complications in firsttrimester manual vacuum aspiration abortion done by doctors and midlevel providers in South Africa and Vietnam: A randomized controlled equivalence trial," *Lancet* 368 (2006), pp. 1965–1972; T. D. Ngo, M. H. Park, and C. Free, "Safety and effectiveness of termination services performed by doctors versus midlevel providers: A systematic review and analysis," *International Journal of Women's Health* 5 (2013), pp. 9–17; World Health Organization. *Worker roles in providing safe abortion care and post abortion contraception* (Geneva: World Health Organization, 2015).

21. A. P. Ndembi Ndembi (2018, see note 6).

22. World Health Organization (2014, see note 7).

23. B. M. Knoppers, I. Brault, and E. Sloss, "Abortion law in Francophone countries," *American Journal of Comparative Law 38/4 (1990), pp. 889–922.*

24. *Loi no. 042/2018 du 05 juillet 2019.* Available at http://www.droit-afrique.com/uploads/Gabon-Code-2019-penal.pdf; A. Mussavu, "Avortement : Le Gabon préfère une interruption thérapeutique mais limitée dans le temps," *Gabon Review* (November 4, 2019). Available at https://www.gabonreview.com/blog/avortement-le-gabon-prefere-une-interruption-therapeutique-mais-limitee-dans-le-temps.

25. P. Nguema-Obam, *Fang du Gabon: Les tambours de la tradition* (Paris: Éditions Karthala, 2005), pp. 22–23.

They Are Girls, Not Mothers: The Violence of Forcing Motherhood on Young Girls in Latin America

XIMENA CASAS

Abstract

Rape of girls under the age of 14 is common in Latin America, and forced pregnancy and motherhood among these girls is a major public health and human rights problem. Even though abortion in the case of rape is legal in a handful of the countries in the region, and is legal in most countries when the life or health of the pregnant woman is in danger, many girls under 14 are forced to continue pregnancies conceived due to rape and to become mothers long before they have the capacity to do so.[1] The paper demonstrates how forced pregnancy and motherhood among girls aged 9–14 in the Latin America region who have been the victims of rape adversely affects all aspects of their health and lives, exacerbated by discrimination and the absence of legal abortion services. It then describes a multidimensional strategy, which includes legal, communications, and advocacy work developed by Planned Parenthood Global and partners in response to these realities. This unique strategy seeks to ensure that access to legal abortion is universally available and accessible to girls aged 9–14 on the grounds that continuing pregnancy poses a serious risk to their health and lives.

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Background: The extent of the problem

Latin America is the only world region where births by girls under the age of 15 are on the rise.[2]

Forced sex, pregnancy, and motherhood in girls aged 9–14 are a prevalent and serious consequence of gender-based violence and discrimination globally, including in Latin America. Yet governments have failed to develop a comprehensive response that is consistent with their obligations to protect the rights and health of girls. In many Latin American countries, abortion is legal where there is a risk to the pregnant girl's or woman's health or life. Thus, girls who are pregnant due to rape should be able to access legal abortion without barriers. Nevertheless, almost all Latin American states not only fail to protect girls from sexual assault and to punish the perpetrators but, through inaction and negligence, also force the girls to continue pregnancies arising from rape, forcing them to become child-mothers.

The *Stolen Lives* report published by Planned Parenthood Global demonstrates—through the stories of 207 girls—the severe impact that forced pregnancies and forced motherhood have on girls.[3] The report speaks to the experiences of the 2 million girls under 15 worldwide who give birth every year as a result of sexual violence. All of the girls in the report are from marginal urban or rural areas and were less than 14 years old when they were raped and became pregnant. They all stopped going to school, and none of them were informed of the pregnancy options available to them or granted access to abortion, even when it was legal. As girls from disadvantaged communities, their inability to access vital reproductive health services, let alone emotional or psychological support, exacerbated the trauma they had experienced and left them vulnerable to revictimization and further human rights violations. The similarities in their stories are striking.

Sexual violence has severe and profound health impacts for girls.[4] However, when that violence causes an unwanted pregnancy, and girls are forced into motherhood, the effects are multiplied and magnified. Even more, these girls not only have to endure the inherent suffering from sexual violence and try to survive the severe consequences of forced motherhood, but they lack access to justice, with the perpetrators of those crimes generally living with impunity. To illustrate that reality, I will share the story of Juana, an indigenous girl from Alta Verapaz, Guatemala, who was raped the first of many times at the age 11 by her half-brother, and who became pregnant at the age of 13. She was forced to carry her unwanted pregnancy to term, and she was told by her stepfather that it was her fault.[5] In Guatemala, abortion is legal when needed to avoid risk to a woman's life. However, that exception has been interpreted restrictively, considering only cases of severe physical complications and without acknowledging that the mental and social impacts of forced pregnancies and forced motherhood also pose threats to girls' health and lives.

The severe physical, mental, and social health impacts of forced pregnancies and motherhood

The *Stolen Lives* research found that the physical, mental, and social health consequences of forcing a girl to carry an unintended and unwanted pregnancy to term are dire, especially when the girl is a survivor of sexual violence. It also corroborates findings from other research on related issues, including physical impacts, mental impacts, and social health.

With respect to physical impacts, research has established that physical complications from forced pregnancy are especially common in girls, with the most serious being preeclampsia and preterm labor; that the risk of dying during childbirth is four times higher for girls than for adult women; and that complications during pregnancy and childbirth are the leading cause of death for 15- to 19-year-old girls globally.[6] Furthermore, with regard to less documented physical impacts, young girls who are survivors of sexual violence are often victims of obstetric violence or mistreatment. They are denied the specialized sexual and reproductive health services they need in that situation and are often forced to suffer through comments and attitudes from medical staff who do not consider their situation of violence or their social environment.[7] The performance of Caesarean sections is

becoming a common method of delivery for young girls, especially in Guatemala and Nicaragua. It is important to highlight that this is not for medical reasons but because of a lack of specialized training to properly deal with the specific needs of sexual violence survivors. Performing a Caesarean section at such an early age has very serious health consequences, including a risk of direct complications of surgery and later formation of adhesions.[8]

Mental impacts are equally severe. Forced motherhood causes feelings of anxiety, fear, and depression, and Planned Parenthood Global's investigation revealed that it also leads to suicide and suicidal thoughts.[9] Research has also shown that suicide is disproportionately associated with adolescent pregnancy, particularly in settings where reproductive choice is limited.[10] A 2019 report on Guatemala entitled *Silenced Lives* indicates that 50% of the teenage girls who committed suicide in Alta Verapaz in 2017 were pregnant.[11] As noted above, Juana was also from Alta Verapaz, Guatemala. As a result of her pregnancy, she became very depressed and almost suicidal. In her statement she said, "I want to die; my heart is not happy like before."[12]

Finally, social health should also be considered. As revealed by *Stolen Lives*, both early pregnancy and motherhood diminish the expectations of child-mothers and their families for the future. Their life plans are upended, limiting their ability to continue their education or find stable or even subsistence employment to support both themselves and their child. Many girls are forced to drop out of school, never to return, and are exposed to higher levels of poverty and abusive relationships.[13] The report also points to a number of other poor social outcomes: women who become teen mothers are less likely to complete high school, more likely to work at low-income jobs and experience longer periods of unemployment, more likely to receive welfare benefits during the years following birth, and more likely to experience single parenthood and higher levels of poverty.[14] Indeed, across the four countries in the study, 33% of the girls had attended only primary school. Without an income, with little education, and with little chance of obtaining either, social and personal opportunities are generally significantly limited. Pregnancy tends to remove a child-mother from her environment: she loses her family and her peer group at school, the opportunity for recreation with her age group is removed, and her presence in the community is greatly altered. Indeed, her whole life is altered. Her situation reinforces stereotypes of behavior and social and cultural practices, leading to discrimination against her, based on concepts of inferiority and subordination. Juana, for example, wanted to finish primary school but could not. She was forced to live in a government facility until she reached legal age.

Culture of impunity in cases of sexual violence

Sexual violence is likely to go unreported. However, even when a report is filed, a culture of impunity prevails and, frequently, no arrest is made, even if the survivor can provide identifying information on the perpetrator.[15]

In South America, Peru is the country with the highest rates of reports for sexual violence, with 22.4 reports of rape for every 100,000 inhabitants.[16] Peru also has yet to fully comply with either of the two United Nations (UN) decisions related to access to abortion: *KL v. Peru* (Human Rights Committee) and *LC v. Peru* (Committee on the Elimination of Discrimination against Women). In Ecuador, the percentage of prosecutions that are initiated in the criminal system is very low relative to all complaints of violence against women. For example, in Guayaquil, legal proceedings were initiated in only 12% of complaints in one year.[17] The percentage of legal cases reaching a conclusion is also low, with 2% of cases coming to judgment.[18] In Guatemala, only 33% of sexual crime cases go to trial.[19]

There are several reasons why legal remedies may prove to be ineffective. Police and other authority figures in Latin American countries may not believe the girl, or they may choose not to take her complaint seriously.[20] And even judges fail to treat sexual or domestic crimes with the same importance as drug or murder cases and therefore do not give the complainants equal treatment.[21]

In some instances, reporting a case to authorities may worsen the survivor's position by "outing"

them to their community and potentially exposing them to more abuse.[22] In the case of Juana, her rape was duly reported to the authorities, and her stepfather even recognized the abuse committed by his son, but he blamed Juana for being sexually provocative. As a result, Juana was sent to a maternity house in a city far from her community as a measure of "protection" and "security." No criminal proceedings against the rapist followed.

A multidimensional strategy to confront a structural problem: Forced motherhood among girls

For years, the stories of Juana and thousands of girls like her have remained unheard. Moreover, the restricted application of abortion policy has prevented access even in cases when abortion would be legal. Both of these factors contribute to furthering social stigma and allowing impunity around sexual violence to prevail. However, the egregious nature of these cases has provoked outrage and empathy across the region. While public attention has slowly begun to build around the issue of sexual violence perpetrated against young girls, the policy responses from governments and civil society have focused on seeking better prosecution and punishments of the aggressors, rather than centering a response around the victims and a comprehensive view of the long-term impact on their lives. As a result, starting in 2014, Planned Parenthood Global developed a multidimensional strategy to address the issue of forced motherhood in girls. The aim was to generate evidence, build public support, and develop legal arguments in support of abortion access for these extreme cases of forced pregnancy, using the lens of the right to health. This put forth a novel argument for access to legal abortion for all cases of forced pregnancy resulting from rape in girls aged 9–14: that by virtue of their age, these girls inevitably face a risk to their health and life and that existing legal abortion allowances for life or health should therefore automatically extend to them. The countries that allow for these cases of legal abortion were failing to implement their own policies. At Planned Parenthood Global, we thought it was time to give girls a voice and a platform to claim their rights—to let them be girls, not mothers.

This multidimensional strategy has four components, as described below.

Research and evidence

Between 2014 and 2015, Planned Parenthood Global, in partnership with the O'Neill Institute at Georgetown University and Ibis Reproductive Health, developed a project and methodology for qualitative and quantitative research to document the physical, mental, and social health consequences of forced pregnancy in girls.[23] This research was conducted in Ecuador by Fundación Desafío, in Guatemala by OSAR, in Nicaragua by Asociación de Mujeres Axayacatl, and in Peru by Promsex.[24] Each country published its own national report, and Planned Parenthood Global compiled these results into a regional document entitled *Stolen Lives: A Multi-country Study on the Health Effects of Forced Maternity in Girls Aged 9–14 Years*.[25] The goal was to analyze both patterns of human rights violations and the impact that forced motherhood and unwanted pregnancies have on the overall health of girls.

With this evidence, advocacy work began both at the regional level before the inter-American system and at the country level through the national organizations. The aim was to start a dialogue with decision makers about the importance of understanding this phenomenon from a public health and human rights perspective, as well as to embark on a sensitization process with other key audiences.[26]

Dissemination of information and social mobilization

There are multiple barriers to ending forced motherhood for girls, including some that are less tangible and even more pervasive than restrictive abortion laws, such as stigma, misinformation, and structural gender inequalities that limit girls' decision making.

To build on the research, in 2016 Planned Parenthood Global, in alliance with Amnesty International, Consorcio Latinoamericano

contra el Aborto Inseguro (Latin American Consortium against Unsafe Abortion), and Grupo de Información en Reproducción Elegida (Group for Information on Reproductive Choice), launched a multiplatform communications campaign called "Niñas, No Madres" ("Girls, Not Mothers") to inform and engage the public about the serious consequences of sexual violence and forced motherhood in the lives of Latin American girls, as well as to mobilize civil society to demand the protection of girls' rights.[27] The campaign has become a regional movement in favor of the rights of Latin American girls, and the slogan "Girls, Not Mothers" has promoted and framed a social conversation that has put access to legal abortion at the center, as a necessary measure to protect the rights and well-being of Latin American girls.

Forging alliances

To generate powerful movements, Planned Parenthood Global understands that we need to work with a wide range of organizations, including but not only those in the sexual and reproductive health and rights field. For this strategy, it was critical for us to develop a range of alliances with international, regional, and national civil society organizations interested in providing, promoting, and defending access to care, particularly for girls.

We worked to generate synergy and a peer group of allies that recognized the strengths and challenges of each. We also sought the support of a diverse range of international and national organizations based on an analysis of potential government responsiveness to different pressure points. This diversity lent strength to the overall strategy. While coordination was not always easy, the value added of each organization and alliance, and the role that each could play, increased the effectiveness of the broader approach.

Strategic litigation

Based on our understanding of the power of the law as a tool for social change, in 2018 we began the process of developing, with our allies, a strategic litigation approach to generate a progressive standard for legal abortion for girls.[28] This work seeks to integrate the concept of a dignified life for girls into national policies for legal abortion on the existing grounds of health and life in a number of countries.

Together with the Center for Reproductive Rights, various national partners (Mujeres Transformando el Mundo in Guatemala; Observatorio en Salud Sexual y Reproductiva in Guatemala; Fundación Desafío in Ecuador; Surkuna in Ecuador; and Asociación de Mujeres Axayacatl in Nicaragua), and the law firm Debevoise & Plimpton LLP, we have been working to call attention to human rights abuses experienced by girls (and women) who are subjected to sexual violence in Latin America and who do not have access to sexual and reproductive health care, including safe, legal abortion.[29]

In 2019, we brought four cases simultaneously before the UN Human Rights Committee.[30] With these cases (Fátima, Lucía, Norma, and Susana), we called for the governments to be held accountable for transgressions of the law and the girls' human rights.[31] The committee's decision is likely to take approximately four years.

Forced motherhood among girls also arises from a distinct pattern of human rights violations. Though every instance of sexual violence is personal, the violence, trauma, and human rights abuses that these girls experience are part of the social landscape that defines being a girl. The inability of girls to obtain safe and legal abortion violates their rights to life; to integrity; to health; to gender equality; to freedom from torture and cruel, inhuman, and degrading treatment; to freedom from discrimination; to be heard on matters that affect them; and to a private life.[32]

The four cases brought before the court centered on the following stories.

- **Fátima (Guatemala):** Fátima was 12 years old when she was raped by her teacher, a man who was also financially supporting her mother and her family. Fátima realized that she was pregnant approximately three months after she was abused, and due to the trauma, remembers nothing from her pregnancy. "I could not believe when the doctor told me I was going to have a child, how could I be a child's mother? I was a

child!"[33] State officials were aware that Fátima did not want to carry her pregnancy to term, that her mental health was deteriorating, and that she was expressing suicidal thoughts. However, she was not offered access to abortion services, and she never received any legal or psychological support. Fátima gave birth to a son in September 2010, and a complaint was subsequently filed, resulting in an arrest warrant for her abuser. However, he was never detained, and the process for his capture and arrest has yet to move forward. To date, Fátima has received no justice for the crimes committed against her or for the human rights violations she experienced.[34]

- **Lucía (Nicaragua):** After being sexually abused by a priest for more than a year, Lucía discovered that she was pregnant when she was 14. She became socially isolated as a result of the pregnancy and was taunted by her community for being "the woman of the priest." Shamed and stigmatized for the sexual violence she experienced, Lucía was forced to drop out of school. Despite his known whereabouts, an official complaint, and a DNA test proving that he was the father, the priest has faced no legal consequences for his crimes. Lucía was never offered access to sexual and reproductive health services. To date, she has received no justice for the crimes committed against her and the human rights violations she experienced.[35]
- **Norma (Ecuador):** Starting at the age of 12, Norma was repeatedly sexually abused by her father. At age 13, she discovered that she was seven months pregnant. Her brother filed a complaint with the police, but nothing was ever done. No one offered her sexual and reproductive health services. Desperate and traumatized, Norma attempted to kill herself. Despite the obvious effects that the pregnancy had on her mental health, she never received psychological support, and a private doctor told her that her pregnancy was too far along for a therapeutic abortion to be possible. During labor, Norma refused to be touched, prompting the doctor to comment that since she had opened her legs before, why could she not do so now. After a traumatic birth experience, Norma was continually asked whether she wanted to keep the baby, but was given no information regarding other options, though one doctor offered to buy the child. Until now, Norma has received no justice for the crimes committed against her or for the human rights violations she experienced.[36]

  > *I never imagined that my father would abuse me. I was asleep and he began to fondle me, dreamily, as if he was dreaming. Time passed. Another time he wanted to abuse me, I said no, he said if I didn't let him he would hurt my brother. I was afraid that he would do something to my brother so I permitted it because I was scared. He continued, I didn't want it so he did it by force ... He knew to say that if I didn't let him, he would kill my brother and himself ... Time passed, I was 12 at that point, at 13 I got pregnant and at 14 I gave birth ... I couldn't deliver normally, because by that time I had been raped repeatedly and I didn't want anybody to even touch me, it scared me. So they did a Caesarean ... I didn't let them [examine] me because I just cried, my vagina hurt, it felt awful when the doctor did the exam. The doctor said, "Then, miss, go to another hospital" because I wouldn't let her examine me.*[37]

- **Susana (Nicaragua):** Susana's grandfather began sexually abusing her when she was six years old, and at 13 she became pregnant. In addition to the lack of psychological and legal support and sexual and reproductive health services, Susana had no access to maternal health care during her pregnancy. Since giving birth, Susana has received repeated death threats from her grandfather. She repeatedly tried to file complaints with the police but each time was told that they did not have the proper jurisdiction to take action. Her criminal complaint was rejected five times and then archived under the argument that she did not follow up. She is still fleeing from her aggressor. To date, Susana has received no justice for the crimes committed against her and for the human rights violations she experienced.[38]

From strategy to reality: A tool to advance reproductive rights

The four components of the multidimensional strategy—research and evidence generation; dissemination of information and social mobilization; forging alliances; and strategic litigation—each had tactical purposes in and of themselves. But as a multipronged, integrated approach, the combination has enabled advances to protect the health and life of girls in Latin America by expanding access to legal abortion.

One example illustrating the success of this strategy at the national level is the case of Ecuador. Within the framework of the reforms to the country's Criminal Code, the Ecuadorian organizations leveraged the regional strategy to support their advocacy efforts in 2018-2019, to advance the decriminalization of abortion in cases of rape. For example, Fundación Desafio triggered the move towards reform with the evidence generated by *Stolen Lives*. This then led to public mobilization in Ecuador, which was bolstered by the regional campaign Niñas, No Madres. As a result, the national advocates ensured that the public debate focused on the issue of girls and their lack of access to legal abortion. The parliamentary debate of a bill to decriminalize abortion coincided with the international litigation before the UN Human Rights Committee with the case of Norma, giving the national organizations another opporunity to highlight the impact of the restrictive policy.

The result was a historic watershed moment for the women's movement in Ecuador. While the proposal came five votes short of the 70 needed for approval, there were more votes in favor than against (65 versus 59).[39] The overall strategy led by the national organizations had enabled decisive progress in the national discourse, with increasingly favorable media coverage and a robust cohort of new allies publicly supporting decriminalization, including children's rights, labor, medical, legal, faith-based, environmental, and indigenous rights organizations. This broad alliance made frequent reference to the overall impact that forced pregnancy has on girls, citing not just the physical but also the mental and social health effects.

Forced motherhood: An issue of violence and gender-based discrimination that exposes systematic and serious public health problems and human rights abuses

Structural violence—that is, the systematic ways in which social structures harm or otherwise disadvantage individuals—exacerbated by gender-based discrimination is demonstrated by each plaintiff in the four cases brought before the UN Human Rights Committee. Fátima, Lucía, Norma, and Susana each come from a rural area, and each girl was less than 14 years old when she was raped and became pregnant. As girls from disadvantaged communities, their inability to access vital reproductive health services exacerbated the trauma they had already experienced and left them vulnerable to revictimization and new violations of their rights. All of them stopped going to school, and none were informed of the options available within the health system of their countries, much less granted access to a legal abortion. They each filed an official complaint with authorities, yet none of the aggressors have been arrested or charged. The similarities in their stories are striking and speak to the systematic violations represented by their cases.

The relationship between sexual violence, lack of access to abortion, and forced motherhood

In Latin America, pregnancy among girls under 14 is a major public health and human rights problem. In Ecuador, every day, seven girls under this age give birth as a result of sexual violence.[40] In Mexico, 60% of the perpetrators of sexual violence are girls' relatives or acquaintances.[41] In Guatemala, pregnancy is the primary cause of school desertion for girls and adolescents.[42] Data from the Health Information Management System of the Guatemalan Ministry of Public Health and Social Services show that in 2012 alone, 3,100 pregnancies were reported in girls aged 10–14. This number increased in the following two years, with 4,220 births and

5,100 births reported in 2013 and 2014, respectively.[43] In Peru, there are about 50,000 births each year to mothers under the age of 20, and according to statistics from the Ministry of Health, there were more than 1,100 births to child-mothers aged 12–13 in 2013. This means that three or four girls of this age become mothers in Peru each day.[44] In Colombia, 5,362 girls aged 10–14 gave birth in 2018.[45]

Abortion regulations in Latin America, whether through total bans or restrictive interpretations of the law, impede survivors of sexual violence from accessing safe and legal abortions.

Two options, but no free choice: Illegal, unsafe abortion or forced motherhood

Some countries still maintain a total ban. Others allow therapeutic abortion under certain exceptions, yet their narrow interpretation of "risk to the life or health" to mean an imminent physical risk implies that girls who are survivors of sexual violence rarely have access to the legal abortion they need and would otherwise be entitled to. Girls and women who do not wish to have a child resulting from sexual violence are thus forced to seek illegal, unsafe abortions or to carry unwanted pregnancies to term. Both choices result in physical, mental, and social health problems.

The violation: Right to a life with dignity, including the right to develop life plans

When a girl under 14 years old becomes pregnant, her present and future prospects change radically, and rarely for the better. She faces serious health problems from pregnancy in an undeveloped body (including the risk of death), and her vulnerability is multiplied by already existing poverty, exclusion, violence, and dependency. The right to a life with dignity requires states to ensure that girls can fulfill their life plans, such as continuing their education, pursuing a rewarding professional life, and being able to socially engage in their communities.[46]

Discussion

In most Latin American countries, abortion is legal when there is a risk to the pregnant woman's life or health. In practice, however, these grounds are interpreted in the narrowest possible sense, which severely limits access to safe and legal abortion. Girls who have been raped experience social, emotional, and psychological damage, as well as serious physical damage to their bodies, internally and externally, the more so if they have been raped repeatedly.

Although Fátima, Norma, Susana, and Lucía expressed strong wishes not to continue with pregnancies imposed on them through rape, they were not heard and were forced by others to become child-mothers. Based on personal, moral, or religious views, justice officials and health care providers ended up abusing their authority and prolonging and exacerbating the mistreatment of the very girls they were responsible for protecting. Nor had most of the public officials received any form of training or education that might help them challenge their own assumptions and beliefs in this area. Decisions like these are commonplace throughout Latin America, and girls are not being treated with dignity or impartiality, let alone sympathy and support. The outcome is region wide violations of girls' rights, hindering their access to justice, and denying their sexual and reproductive rights.

Governments, civil society, communities, and international agencies must do more to protect girls and support their safe and healthy transition from childhood and adolescence to adulthood. Comprehensive sexual and reproductive health and safe, legal abortion services must be accessible to end forced pregnancy and mitigate its consequences for girls globally. All pregnancies in girls are high risk, and, therefore, legal termination of pregnancy should always be permitted. This is the only way to fully protect and fulfill the rights of girls.

The lasting effects on girls' physical, mental, and social health represent a serious violation of their human rights. States have a responsibility not only to prevent this form of violence but also to respond appropriately when girls experience it, as a matter of gender equality and non-discrimination, including by providing access to abortion without delay when girls become pregnant as a result.

Despite Latin American states' formal and legal recognition of violence against girls and

women as a priority issue to address, there is a large gap between the prevalence and severity of the problem, on the one hand, and the quality and effectiveness of a judicial response, on the other.[47] According to the Inter-American Commission on Human Rights, most cases of gender-based violence are never formally investigated, prosecuted, or punished by the justice systems in the region.[48] Victims of violence do not receive expeditious, timely, or effective access to judicial remedies when reporting the events.[49] This has generated a pattern of systematic impunity in the proceedings and in the prosecution of these cases.

The health sector is an important place where women, particularly girls, should be able to find support after experiencing sexual violence. Health care providers can play a significant role in supporting girls' recovery, or they can add to their continued victimization.[50] In order to support girls' recovery, these providers should have training that helps them understand and take into account the experiences, needs, and demands of the survivors.[51] However, the Inter-American Commission on Human Rights has noted a number of failures in the operation of government programs designed to provide multidisciplinary services to victims of violence in Latin America. Among these, it has highlighted "the lack of coordination and cooperation between programs; deficiencies in the provision of interdisciplinary services required by victims; lack of resources to sustain programs; and limited geographical coverage, which particularly affects women living in marginalized, rural and poor areas."[52] Although this statement is about the situation of affected women, it is equally appropriate and relevant in the case of girls.

Conclusion

Systemic sexual violence paired with minimal access to and denial of sexual and reproductive health services means that girls in Latin America are frequently forced to carry unwanted pregnancies to term and become child-mothers, with consequences lasting the rest of their lives. In the small number of cases that have been filed before regional and international human rights bodies, these mechanisms have confirmed in no uncertain terms that forcing a girl to carry to term a pregnancy resulting from rape has severe mental and physical health consequences and constitutes a violation of her right to health.

Due to either total criminalization or the presence of unlawful barriers that limit the interpretation of the right to health, girls are being denied access to abortion following sexual violence. As the cases of Fátima, Lucía, Norma, and Susana show, the profound impact that this has on physical, social, and mental health leaves girls vulnerable to a higher risk of maternal mortality and morbidity, anxiety, depression, post-traumatic stress, and attempted suicide—which is compounded by living in poverty and being revictimized by the very systems designed to keep them safe.

These forms of violence, both sexual and institutional, are the product of the great inequalities of gender, class, race, and ethnicity that characterize the lives of girls in Latin America. Rape, forced pregnancy, and forced motherhood are forms of cruel and degrading treatment. We cannot continue to allow judicial and health care systems to normalize the situations that force girls to become mothers following rape, often repeated rape. Neither can we allow the lifelong consequences of the violence and gender-based discrimination girls have suffered to be met with silence or to go without justice or reparations.

References

1. Center for Reproductive Rights, *The world abortion map*. Available at https://reproductiverights.org/worldabortionlaws.

2. United Nations Population Fund, *The state of world population 2013: Motherhood in childhood* (New York: United Nations Population Fund, 2013).

3. X. Casas, O. Cabrera, R. Reingold, and D. Grossman, *Stolen lives: A multi-country study on the health effects of forced motherhood on girls 9–14 years old* (Planned Parenthood Global, O'Neill Institute for National and Global Health Law, and Ibis Reproductive Health, 2015). Available at https://www.plannedparenthoodaction.org/uploads/filer_public/db/6d/db6d56cb-e854-44bb-9ab7-15bb7fc147c5/ppfa-stolen-lives-english.pdf; World Health Organization,

Adolescent pregnancy (February 2018). Available at https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy.

4. United Nations Children's Fund, *Together for girls: Sexual violence fact sheet* (2012). Available at https://www.unicef.org/protection/files/Together_for_Girls_Sexual_Violence_Fact_Sheet_July_2012.pdf .

5. Casas et al. (see note 3), p. 40.

6. Ibid., p. 24; World Health Organization, *Maternal mortality* (2019). Available at https://www.who.int/news-room/fact-sheets/detail/maternal-mortality; World Health Organization, *Adolescent pregnancy* (2018). Available at http://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy.

7. Casas et al. (see note 3), pp. 8, 38.

8. Ibid. p. 23.

9. Ibid. pp. 24–25.

10. World Health Organization and United Nations Population Fund, *Mental health aspects of women's reproductive health: A global review of the literature* (Geneva: World Health Organization, 2009).

11. FLACSO Guatemala, *Vidas silenciadas, una tragedia de la que no se habla: Vinculación entre suicidio y embarazo en mujeres adolescentes (2009–2019)* (Guatemala City: FLASCO Guatemala, 2019), p. 91.

12. Casas et al. (see note 3), p. 39.

13. Ibid. p. 26.

14. Ibid. pp. 38–39.

15. Ibid.

16. Immigration and Refugee Board of Canada, *Peru: Domestic violence, including femicide; legislation; state protection and support services available to victims (2014–February 2018).* Available at https://www.refworld.org/docid/5ad09d424.html; J. Mujica, *Violaciones sexuales en Perú 2000–2009: Un informe sobre el estado de la situación* (2011). Available at https://promsex.org/publicaciones/violaciones-sexuales-en-el-peru-2000-2009-un-informe-sobre-el-estado-de-la-situacion.

17. Inter-American Commission on Human Rights, *Access to justice for women victims of sexual violence in Mesoamerica* (2011), p. 17.

18. Ibid., p. 18.

19. Ibid.

20. M. Ellsberg, A. Winkvist, R. Pena, and H. Stenlund, "Women's strategic responses to violence in Nicaragua," *Journal of Epidemiology and Community Health* 55/8 (2001), pp. 547–555.

21. Inter-American Commission on Human Rights (see note 17).

22. S. Bott, A. Guedes, M. Goodwin, and J. A. Mendoza, *Violence against women in Latin America and the Caribbean: A comparative analysis of population-based data from 12 countries* (Washington, DC: Pan American Health Organization, 2012), pp. 57–59.

23. For more information, see https://www.plannedparenthood.org/about-us/planned-parenthood-global; https://oneill.law.georgetown.edu/; https://www.ibisreproductivehealth.org.

24. For more information, see https://www.fundaciondesafio-ec.org/; https://osarguatemala.org/; http://asociaciondemujeresaxayacatl.org/; https://promsex.org/.

25. Casas et al. (see note 3).

26. Inter-American Commission on Human Rights, Thematic hearing, Montevideo, October 24, 2017. Available at https://www.youtube.com/watch?v=KEmz-37bw_TI&list=PL5QlapyOGhXvdhUdWzbRmDhN-QU-Fs3U-2&index=12&t=0s.

27. See www.ninasnomadres.org. For an English summary, see https://www.youtube.com/watch?v=mzT6zPJzZL4.

28. L. Ford, "Latin America rape survivors who were denied abortion turn to UN," *Guardian* (May 29, 2019). Available at https://www.theguardian.com/global-development/2019/may/29/latin-american-survivors-who-were-denied-abortions-turn-to-un.

29. For more information, see https://reproductiverights.org/; https://www.mujerestransformandoelmundo.org/; https://osarguatemala.org/; https://www.fundaciondesafio-ec.org/; http://surkuna.org/sitio/; http://asociaciondemujeresaxayacatl.org/.

30. Planned Parenthood Global, "Innovative litigation filed against 3 countries to protect girls' rights in Latin America" [press release], May 2019. Available at https://www.plannedparenthood.org/about-us/newsroom/press-releases/innovative-litigation-filed-against-3-countries-to-protect-girls-rights-in-latin-america.

31. Ford (see note 28).

32. Center for Reproductive Rights, *They are girls: Reproductive rights violations in Latin American and the Caribbean* (New York: Center for Reproductive Rights, 2019).

33. K. López, "Fátima y las niñas obligadas a ser madre en Guatemala," *Nómada* (May 29, 2019). Available at https://nomada.gt/nosotras/somos-todas/fatima-y-las-ninas-obligadas-a-ser-madres-en-guatemala/.

34. See the full story in Spanish at https://www.ninasnomadres.org/ninas-obligadas-ser-madres/fatima-guatemala/.

35. Center for Reproductive Rights (see note 32).

36. Casas et al. (see note 3), pp. 36–38.

37. Ibid., pp. 37–38.

38. Ibid., p. 48.

39. "Ecuador abortion: National Assembly rejects easing law in rape cases," *BBC News* (September 18, 2019). Available at https://www.bbc.com/news/world-latin-america-49739495.

40. Ford (see note 28).

41. Ibid.

42. Ibid.

43. See monitoring report conducted by the OSAR Guatemala national network (March 2015).

44. For more information, see INEI, *Perú: Encuesta Demográfica y de Salud Familiar-ENDES* (2013). Available at https://dhsprogram.com/pubs/pdf/FR299/FR299.pdf.

45. National Administrative Department of Statistics, Colombia, *Nacimientos 2018: Preliminar.* Available at https://www.dane.gov.co/index.php/estadisticas-por-tema/salud/nacimientos-y-defunciones/nacimientos/nacimientos-2018.

46. Human Rights Committee, General Comment No. 36, The Right to Life, UN Doc. CCPR/C/GC/36 (2018).

47. Inter-American Commission on Human Rights (see note 17), p. 6.

48. Ibid.

49. Ibid., p. 1.

50. D. Billings, A. Valenzuela, and J. M. Place, *Mujeres víctimas-sobrevivientes de violencia sexual y sus experiencias con los servicios de salud disponibles en Guatemala* (Ipas, 2011).

51. Ibid.

52. Inter-American Commission on Human Rights (see note 19), p. 17.

The Gambia's Political Transition to Democracy: Is Abortion Reform Possible?

SATANG NABANEH

Abstract

The aim of this paper is to assess The Gambia's laws on abortion. It argues that the restrictive laws on abortion are less a function of religious doctrine and more due to the historical and contemporary structure of the Gambian state, influenced by autocratic rule. As such, the current shift from an authoritarian regime to a democratic one suggests that there may be potential for legal mobilization in the advancement of women's sexual and reproductive rights, including broadening the legal grounds for abortion. In order to achieve the right to safe abortion, the article suggests that a critical mass of support through collaborative networking between parliamentarians, health professionals, human rights activists, the media, and women's rights supporters is needed. Advocacy for expanding the grounds for safe abortion would be premised on international norms and standards, as well as support for research on the magnitude of unsafe abortion and its impact, while addressing the sociocultural context. These different strategies should be adopted to expand access to safe, legal abortion in The Gambia.

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Background: Colonial history

The Gambia, mainland Africa's smallest state, became a British colony in 1821, as part of British West African settlements under the jurisdiction of the governor of Sierra Leone, and became a separate colony in 1888.[1] It achieved independence on February 18, 1965, as a constitutional monarchy within the Commonwealth. On April 24, 1970, it became a republic following a majority-approved referendum.[2]

Prior to the advent of colonial rule, issues of women's sexuality would have been governed through customary law. There is very little record existing about the attitudes of Gambian society towards abortion before or during colonialism. During colonial rule, the first documented case of abortion was the Anna Evans case of 1873, in which a leading British merchant accused the then-colonial secretary of administering "noxious drugs" to Evans to cause a miscarriage. Although an investigation was conducted, the matter was dropped because it was doubtful that a conviction would be secured.[3] Punishment seems to have been the exception rather than the rule, if other reports of abortions were any measure. For instance, in 1890, the acting colonial surgeon, Thomas Spilsbury in his report published in the Annual Bluebook noted, "I regret to have to say that I have certain knowledge that abortion is frequently carried out by herbalists in a manner known to the profession."[4]

In the early 1930s, there was a general perception that sex was rampant, and that society was morally decayed due to premarital sex, teenage pregnancy, population explosion, and independent women that came from the rural areas.[5] In response, the colonial administration imposed paternalistic control. For example, on July 26, 1830, the acting governor commented during a presentation on the health of native Gambians:

> *Maternity is still the normal function that it should be, and so normal it is usual that the birth of a child merely causes a few hours' interruption in a woman's occupation… It must be borne in mind that the raison d'etre of marriage among these people [natives] is the propagation of children.*[6]

Accordingly, ordinary people viewed marriage and procreation as women's primary purpose. The entrenchment of patriarchal norms was further facilitated through indirect rule, wherein local leaders institutionalized discriminatory customary law, particularly with regard to women's roles, marriage, and sexuality.[7] The consequences of the subordination of women continues to the present day, with implications for abortion law.

The colonial legacy of a restrictive abortion law in The Gambia

As a former British colony, The Gambia's abortion law mirrors that of the British Offences Against the Person Act 1861, which permits abortion only to save the life of the pregnant woman. The colonially inherited criminal code was only enacted in The Gambia in 1933 due to the colonial administration's perception that there was no need for a separate criminal code in such a small territory with little serious criminal activity.[8]

Section 140 of the Criminal Code makes it a serious offense to procure an abortion for a woman and carries a maximum punishment of 14 years in prison. Section 141 makes it an offense for a woman to procure her own abortion and she becomes liable on conviction to imprisonment for seven years. Section 142 also punishes anyone who supplies a woman with the means for unlawfully procuring an abortion and they are liable to three years' imprisonment. Section 198 serves as the defense for procuring an abortion; it provides that no person shall be found guilty of the offense of destroying a child capable of being born alive if the act was done in good faith to preserve the woman's life. This is based on the British Infant Life Preservation Act 1929.[9]

The grounds for a legal abortion were expanded through subsequent interpretation based on the 1938 British case of *R. v. Bourne*.[10] In *Bourne*, it was held that the abortion performed by a physician on a 15-year-old girl who had been gang raped, putting her at risk of becoming "a physical and mental wreck," was lawful.[11] Thus, The Gambia, through its received common law, to this day permits abortion on the grounds of preserving the physical and men-

tal health of the pregnant woman.[12]

It is important to note, though, that while it has been argued that *Bourne* was obtained in British colonies through common law, there is no evidence that abortions began to be provided on these grounds based on *Bourne*. This is largely due to the fact that the health ground was never tested for legality or reaffirmed in a Gambian court. It is arguable though, that through section 30(1) of the Women's Act 2010, which recognizes risk to the life of the pregnant woman or the life of the fetus as grounds for legal abortion, that the Gambian legislature has shown its intention not to follow the juridical liberalization of abortion law through *Bourne* or any other more liberal legislation.

A major problem with the applicability of received British laws in The Gambia is that while the 1861 and 1929 Acts are both still in place in Britain—and the 1967 Act broadened the grounds for legal abortion far beyond *Bourne*—the abortion provisions in the criminal code remain stagnant.[13]

Women's reproductive rights in The Gambia

During the past few decades, sexual and reproductive health and rights have been recognized as a key part of the international health and development agenda. In 1994, the International Conference on Population and Development (ICPD) brought attention to women's sexual and reproductive health.[14] In addition, during the Fourth World Conference on Women in 1995, notable African women including conference chair Gertrude Mongella helped lead efforts to affirm reproductive autonomy.[15]

The Beijing Platform for Action provided a "holistic view of health and the social, political and economic factors affecting health."[16] These two agreements have contributed immensely to the recognition of women's reproductive rights as human rights.[17] The rights-based approach recognizes that individuals have the right to the highest attainable standard of health, including the right to life, survival, the right to control sexual and reproductive life, and the right to make reproductive decisions.[18]

African momentum around women's reproductive health also continued to expand. At the African regional level, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) was adopted in 2003.[19] Subsequently, General Comment 1 on Article 14 (1) (d) and (e) of the Protocol was passed, relating to protection of the rights of women against sexually transmitted infections, including HIV in 2012.[20] General Comment 2 on reproductive health rights was adopted in 2014.[21] It focuses on measures to promote and protect sexual and reproductive rights of women and girls in Africa, particularly on access to safe abortion.[22]

The Gambia ratified the Maputo Protocol on May 25, 2005, but with reservations. While the Protocol is silent on reservations, Article 19 of the Vienna Convention on the Laws of Treaties (Vienna Convention) allows states to enter a reservation to any treaty.[23] However, reservations by ratifying states cannot be construed as serving to restrict international and regional human rights obligations.[24] At the time of ratifying the Maputo Protocol, The Gambia made blanket reservations to Articles 5 (harmful cultural practices), 6 (on marriage), 7 (on separation, divorce, and annulment of marriage) and 14 (reproductive health rights, including abortion).

The Maputo Protocol has been hailed as the only international human rights instrument that provides for abortion.[25] Article 14, which has two sections, reaffirms women's right to decide when and where to have children, and to have access to sexual and reproductive health information and services, including family planning. The first section ensures that the "right to health of women, including sexual and reproductive health is respected and promoted." The second section requires States parties to take appropriate measures to provide affordable and accessible health services; establish and strengthen pre- and post-natal services for women; and permit medical abortion. Article 14(2)(c) of the Protocol obligates States parties to permit abortion in cases of "sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus."

While the Gambian government did not give any reason as to why it issued reservations to the Maputo Protocol, it can be argued that this was part of the political strategy of former President Jammeh, who used Islam for his own political gain during his 22 years of dictatorship, stretching back to July 1994.[26] Throughout his rule, Jammeh employed various tactics to gain political control and recognition in the Islamic world and among its leaders, using anti-Western rhetoric (including withdrawal from the Commonwealth).[27]

In March 2006, prior to the African Union (AU) Head of States Summit hosted in The Gambia in the same year, the African Center for Democracy and Human Rights Studies, in collaboration with local women's rights organizations and networks, and with the support of Solidarity for Women in Africa, approached the Office of the Vice President and Minister of Women's Affairs and Women's Bureau to put in place an advocacy mechanism which would facilitate the National Assembly Members revisiting these articles.[28] This led to the convening of tripartite meetings comprised of governmental officials, parliamentarians, and selected civil society representatives. All reservations to the Maputo Protocol were eventually withdrawn a few days before the summit.[29]

Premised on Section 28 on women's rights in the 1997 Constitution, as well as the fact that ratified international treaties do not automatically have applicability in national laws, the Women's Act was passed in 2010.[30] This Act is a domesticated legislation resulting from The Gambia's ratification of the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) on April 16, 1993, and the Maputo Protocol, respectively.[31]

Grounds for termination under the Women's Act

Section 30 of the Women's Act 2010 states:

1. Every woman has the right to enjoy reproductive rights including the right to medical abortion, where the continued pregnancy endangers the life of the mother or the life of the foetus.
2. The medical abortion permitted under sub-section (1) shall not be carried out without the confirmation of the state of health of the woman in question by a registered medical practitioner who possesses the necessary expertise in the field.
3. Where the woman in question is in an environment where the necessary medical facilities are not available, appropriate referral shall be made in accordance with systems of medical referrals established in the health system.
4. Where the woman in question is unable to afford the medical expenses involved, Government shall bear the cost of the medical expenses.

The Women's Act falls far short of the comprehensiveness of the Maputo Protocol, as the grounds for abortion do not include rape, sexual assault, incest, or risk to the health of the pregnant woman. In fact, the majority of women of reproductive age in Africa live in countries with highly restrictive abortion laws.[32] All these countries that have ratified the Maputo Protocol have abortion laws that are not in line with its provisions. Additionally, the Act follows the circumscribed grounds despite several interpretations in Islamic jurisprudence as to the circumstances under which women can legally access abortion.[33]

The 2006 withdrawal of reservations on Article 14 of the Maputo Protocol was an opportunity to allow abortion on a broader range of grounds than those outlined in the Women's Act, but this did not happen due to ongoing ambivalence about abortion in Gambian society and state politics.

Firstly, there has generally not been a women's rights-driven advocacy or overall public debate on abortion, unlike in other countries where feminist organizations have been instrumental in the push for progressive laws.[34] The Gambian women's rights movement has made notably contradictory responses and actions on abortion. The majority of women's rights activists view abortion as morally and religiously wrong, and therefore do not consider abortion as a priority in the legal reform agenda for women's rights. Their conservative attitudes are mainly framed within the importance of the institution of marriage and reproduction.[35] An uneasy

tension continues between a focus on the right to decide whether to have children—which resonates with liberal feminism—and support for women's distinct roles as mothers, which is in line with religious and traditional norms.[36] Moreover, women's rights activists are unwilling to act on abortion out of fear that they will lose support for other women's rights issues.

Secondly, members of the women's rights movement likely did not act on abortion because they feared backlash from the then-authoritarian government, whose crackdown on human rights defenders included those supporting sexual and reproductive health and rights. For example, Dr. Isatou Touray, now vice president of The Gambia, and her colleague, Amie Bojang-Sissoho, faced corruption charges in October 2010 after former President Jammeh set up a commission of inquiry to investigate the use of funding by the Gambia Committee on Traditional Practices Affecting the Health of Women and Children to work on FGM.[37]

While the Banjul Magistrates' Court decided to drop all charges in November 2012, the judicial harassment or intimidation faced by these two women human rights defenders shows that the government would step in against an issue it considered sensitive or threatening.

Incidence of unsafe abortion

The Gambia has a youthful population, with 64% below age 24 and 38.5% aged 15–35.[38] The population is expected to double in two decades, due in part to the current high fertility rate, estimated at 5.9 children per woman.[39] According to one of the few studies conducted, the Gambia Family Planning Association estimates that abortions are highest among unmarried adolescents between the ages of 14 and 24, mainly in urban and peri-urban areas.[40] These estimates, published in 1996, are out of date. More recent data on the incidence of abortion is scant, as most cases go unreported or undocumented.[41] However, given that the contraceptive prevalence rate is a meager 9% (8% modern methods and 1% traditional methods), which is among the lowest in Africa, it is reasonable to assert that a large number of unsafe abortions occur.[42]

Unintended pregnancy is a major reason for unsafe abortions in The Gambia, as in most African countries. The extent of early sex and sex outside marriage in a very young population can be deduced from the 2013 Demographic Health Survey, which estimates that 15% of women aged 20–49 had sex before age 15 and 42% before age 18.[43] Twice as many girls aged 15–19 become pregnant in rural areas than girls in urban areas (24% compared to 12%).[44] Limited access to sexual and reproductive health information, few adolescent-friendly health services, lack of reproductive autonomy, and a religious and patriarchal belief that family planning leads to promiscuity all contribute to this phenomenon.[45]

In a Muslim-dominated society such as The Gambia, pregnancy before marriage is a social taboo. Consequently, young women seek to cover up the shame and stigma attached to unplanned pregnancy and the knowledge that they have been sexually active. While pre- and extramarital sex for men is generally accepted, the same is not true for women.[46] Those who get pregnant outside marriage are considered promiscuous and are stigmatized, together with their families. Thus, cultural stereotyping leads many to seek unsafe abortions.

Notwithstanding legal restrictions, women self-induce, often with unsafe methods such as bleach and traditional medicines.[47] Others turn to unqualified practitioners who operate in unsafe and unsanitary environments. As a result, women seek post-abortion care, often for severe complications.

Lack of access to legal and safe abortion is a significant cause of maternal deaths. The Gambia's maternal mortality ratio (443 per 100,000) accounts for 50% of deaths among women aged 25–29 and 36% of all deaths among women aged 15–49.[48] Maternal mortality has largely been due to teenage pregnancy, limited access to skilled birth attendants, and poor quality of emergency obstetric care services.[49] A 2011 study found that young women and girls form the majority of patients treated for complications of unsafe abortion.[50] According to the Ministry of Health, in 2018, there were 1,985 post abortion-care cases in public hospitals nationally.[51] This figure is likely to be much lower than the actual prevalence,

as most women who have abortion-related complications do not seek treatment from a health facility.

Government health facilities are legally allowed to provide abortion services only to save the life of the woman. The misoprostol-only recommended regimens by International Federation of Obstetricians and Gynecologists (FIGO) are used.[52] Apart from the FIGO guidelines, there are no national guidelines or protocols for health professionals to provide abortions. However, due to misunderstandings about the legality of the procedure, leading to fear of prosecution, doctors are dissuaded from providing abortions.[53]

As of this writing, implementation of the National Health Policy Framework (NHPF) 2012-2020, developed in 2012 during Jammeh's regime, is ongoing. However, it conspicuously does not address the issue of abortion or post-abortion care services at all.

Influence of human rights bodies

Human rights treaty monitoring bodies have put pressure on The Gambia to liberalize abortion, based on the country's ratification of international and regional human rights instruments. For example, the Human Rights Committee noted in 2004 that the restrictive abortion law results in unsafe abortions, which contribute to a high rate of maternal mortality.[54] The Committee on the Rights of the Child also urged the Gambia in 2015 to decriminalize abortion and ensure that the best interests of pregnant teenagers are guaranteed.[55] In 2015, the Association of Non-Governmental Organizations (TANGO), Women's Rights Organizations (WRO), and Civil Society Organizations (CSOs) highlighted in their shadow report the need to harmonize the laws on abortion in line with the international and regional human rights obligations to promote the sexual and reproductive health and rights of women in The Gambia.

As a result, the CEDAW Committee made similar recommendations to government: to remove all punitive measures, in particular for women undergoing abortion; expand the grounds for legal abortion to cases of rape, incest, and severe fetal impairment; and ensure the availability of safe abortion and post-abortion services.[56] Yet even these leave out the main reason for seeking an abortion— unintended and unwanted pregnancy on social and economic grounds.

Transition to democratic rule

On December 1, 2016, Jammeh lost the presidential election to opposition coalition candidate Adama Barrow, who took office peacefully with the backing and support of the Economic Community of West African States (ECOWAS). Since the transition to democratic rule in January 2017, The Gambia is undergoing a period of rebuilding and transformation. Since assuming office, the government has been fulfilling its reporting obligations under the various human rights treaty monitoring bodies. Most recently, the Human Rights Committee recommended in 2018 that The Gambia should review its restrictive abortion law:

> *… to provide safe, legal and effective access to abortion where the health of the pregnant woman or girl is at risk and where carrying a pregnancy to term would cause the pregnant woman or girl substantial pain or suffering, most notably where the pregnancy is the result of rape or incest or is not viable, and ensure that criminal sanctions are not applied against women and girls undergoing abortion or against medical service providers assisting them in doing so, since taking such measures compels women and girls to resort to unsafe abortion.*[57]

At the Africa regional level, during the previous Jammeh regime there has been a deafening silence on women's rights issues generally relating to The Gambia, due to the country's lack of adherence to its reporting obligations to the African Commission on Human and Peoples' Rights.[58] During the 22 years of dictatorship (1994–2016), The Gambia did not submit a single report to the regional body. In August 2018, the new government submitted a combined report on the African Charter on Human and Peoples' Rights and the Maputo Protocol, which was reviewed in May 2019.[59] The report noted the following:

> *Abortion remains criminalised in The Gambia except when the health or life of the mother is at risk. However, the continued practice of clandestine abortions remains an issue and a concern as it leads to adverse consequences on the health of women and girls. Due to the near total ban on abortion, this has resulted in the paucity of reliable data on the national burden of abortion.*[60]

During the review process, the Special Rapporteur on the Rights of Women in Africa requested further information on steps the government has taken to harmonize and reform its abortion laws in line with the Maputo Protocol. It is anticipated that the concluding observations from the Commission will urge The Gambia to take steps to prevent mortality due to unsafe abortion and comply with its obligations under article 14(2)(c) of the Protocol.

While treaty monitoring bodies' engagement with The Gambia on abortion reform can be seen as a positive development, any optimism must be tempered by the persistent problem of the weak implementation of concluding observations, evident both in the former government's unwillingness and the current government's slow pace.

The potential for law reform

The transition from an authoritarian regime to a democratic government serves as an opportunity for legal mobilization to advance women's sexual and reproductive rights, including broadening the grounds for abortion.

Prior to assuming office, the current government noted that its goal is to establish a democracy that is underpinned by the protection of fundamental rights and freedoms and the rule of law. Within the framework of a transitional justice process, the new government, headed by President Barrow, is implementing sweeping measures, including a review of the constitutional, legal, and institutional framework, as well as the quality of its strategies, policies, and programs in the judiciary, security sector, and civil service. The aim is to consolidate democracy and align the entire governance architecture with international justice and human rights standards.[61]

Given that the state is undertaking key constitutional and legal reforms to bring Gambian laws in harmony with international obligations, it is plausible to argue that the transition represents a significant opportunity for ensuring that critical rights issues, such as the sexual and reproductive health and rights of women and girls, are addressed. While the state has shown little interest thus far in doing so, it is making efforts to provide post-abortion care. For instance, the National Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) Strategic Plan (2017–2021) noted the data gap and need for evidence-based policy and strategy for better provision of post-abortion care services.

While very little is known about entry points and strategies for fostering supportive abortion laws and policy change in The Gambia, strategies from other countries that have been successful in reforming laws on abortion, or are successfully on the road to doing so, can be drawn upon.

Building a national coalition

Coalition-building among key stakeholders is an important component in driving legislative and policy change on issues such as safe abortion. For instance, coalition building was key to law reform in Mexico City and Ethiopia, and for political norm change on abortion despite a restrictive abortion law in Pakistan.[62]

Thus, a movement-building initiative to launch a Sexual and Reproductive Rights Network was set up in May 2019.[63] The new network is made up of individuals and organizations and hosted the first-ever National Coalition Building Meeting on Sexual and Reproductive Health and Rights on May 4, 2019, sponsored by the International Campaign for Women's Right to Safe Abortion. The Minister of Women's Affairs, Children, and Social Welfare attended the meeting.

Attendees deliberated over the need for and focus of a coalition for legal mobilization on abortion in The Gambia. They recognized the need to broaden alliances from a broad spectrum of actors, including health care professionals, women's organizations, legal experts, family planning supporters, and women's rights supporters. This

is particularly important given that, while there is broad consensus on gender equality within the constitutional review process, this has not translated into widespread support for legalizing abortion. For instance, the position paper of the Women's Bureau highlighted the need for reproductive health services for HIV-positive women.[64] The focus on HIV might be as a result of it being addressed as a public health issue, rather than a moral issue, as is the case with abortion. Other proposals include the consideration of the following:

> *Everyone shall have the right to the best attainable standard of health care, which includes the right to health care services, including reproductive health care.*

This proposal has been included under Section 60(1)(a) of the draft constitution released by the Constitutional Review Commission on November 15, 2019. It is contended that if such a right is retained in the new constitution, along with other progressive provisions, including equality and dignity, it can provide an enabling framework for a call for abortion law reform.

In addition, the review and redrafting of the criminal code and the criminal procedure code, spearheaded by the Ministry of Justice, also serves as a good opportunity to advocate for and recommend the removal of punitive abortion provisions. The review is under the framework of The Gambia National Development Plan 2018–2021, United Nations Development Assistance Framework 2017–2021, and the United Nations Office on Drugs and Crime Regional Program for West and Central Africa 2016–2020.

Legal reform

With the primary goal of empowering women to make decisions concerning reproduction, and in line with Article 14 of the Maputo Protocol, abortion law reform in The Gambia would entail expanding the current grounds. The network of activists, lawyers, and health professionals at the May 2019 meeting agreed to work towards changing the law to allow abortion in cases of rape, incest, and health of the pregnant woman. While not a radical move, such a strategy has been used in several countries as it stands a better chance.[65] For example, in 2005, Ethiopia expanded its previous abortion law only to save the life of a woman or protect her physical health, to abortion now legal in cases of rape, incest, or fetal impairment.[66]

Data-driven advocacy and policy engagement

Ongoing and planned legislative and policy reforms are a great opportunity to provide relevant and reliable evidence to drive advocacy and policy engagement. The national coalition-building meeting agreed that there is a need for evidence on the incidence and magnitude of unsafe abortions to support policy engagement and call for the expansion of the existing grounds through engagement with relevant stakeholders. This strategy has been used in other African countries. For example, evidence of unsafe abortion was used by feminists to push for abortion reform on public health needs in South Africa.[67]

This strategy can also support national evidence on maternal mortality through fundraising for the Ministry of Health to conduct such research as part of a broader strategy to address maternal mortality in The Gambia. Advancing work on this front requires a holistic approach to address unsafe abortion-related mortality and morbidity.

In addition, legal reform work should be accompanied by advocacy on the need to invest in sustaining efforts to realize democracy, gender equality, and universal access to the full range of sexual and reproductive health and rights. Indeed, the push for women's political, social, and legal control of their sexual and reproductive rights, including making decisions concerning reproduction, should be grounded in the broader global shift in reproductive rights as they relate to the goals of the UN's Sustainable Development Goals (SDGs) 2030 and the African Union's Agenda 2063.[68]

Conclusion

The Gambia's recent transition from autocratic rule to democratic government offers an opportunity for public debate and legal mobilization on issues of

women's reproductive autonomy. The possible recognition of a right to health care, including access to reproductive health care services, can serve as an enabling framework to amend abortion legislation and remove all punitive measures related to women and girls, and to health care providers. It can also guide expansion of the grounds for legal abortion and ensure accessibility to safe abortion services and post-abortion care in public health facilities.

At this earliest possible stage, advocacy for legal reform is focused on expanding the grounds to include legal abortion in cases of rape, incest, and to protect the woman's health. Conversely, coalition building and national evidence generation on the magnitude and impact of unsafe abortion are necessary. In addition, there is need to utilize international human rights law to hold government accountable for service provision.

Lastly, in order to gain progress, the women's movement needs to be the foremost voice in advocating for abortion reform. The women's movement should be a central element in ensuring that the current government does not renege on its commitment to address women's issues and ensure gender equality.

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References

1. See A. Hughes and D. Perfect, *Historical Dictionary of The Gambia* (2008).

2. S. Nabaneh 'The Gambia: Commentary' in R Wolfrum, R Grote & C Fombad (eds.) *Constitutions of the World* (New York: Oxford University Press, 2017) p. 5.

3. A. Hughes & D. Perfect, *Political History of The Gambia*, (New York: University of Rochester Press, 2006) pp. 74-75.

4. "Report on Blue Book," (1889), p. 14.

5. M. J. Park, "The heart of Banjul: The history of Banjul, The Gambia, 1816 – 1965," (PhD thesis, Michigan State University, 2016), pp. 284-285.

6. "Paper relating to the health of native population," (1930), pp. 142-143 as cited in R.R. Kuczynski, *Survey of the British Colonial Empire*, (London: Oxford University Press, 1948), p. 361.

7. See B. Saho, *Contours of Change: Muslim Courts, Women, and Islamic Society in Colonial Bathurst, the Gambia, 1905-1965* (Michigan: Michigan State University Press, 2018).

8. *Criminal Code Act No. 25 of 1933*, Chap. 10:01, Laws of The Gambia (2009). See also H. F. Morris, "A history of the adoption of codes of criminal law and procedure in British Colonial Africa, 1876-1935," *Journal of African Law* 18/1 (1974), pp. 20-23.

9. R. J. Cook & B. M. Dickens, "Abortion laws in African Commonwealth countries" (World Health Organization, 1979), p. 8.

10. *R v Bourne*, 3 All English Report 615, 1 King's Bench 687 (Central Criminal Court, London) (1939).

11. Ibid., p. 619.

12. See R. J. Cook & B. M. Dickens, "Abortion laws in African Commonwealth countries," *Journal of African Law* 25/2 (1981), pp. 60-79.

13. On the continued applicability of common laws and statutes in The Gambia despite these laws subsequently been declared unsustainable in England and repealed, amended or replaced, see E. A. Agim, *The Gambia legal system* (Banjul/The Gambia: Artwords Production., 2015), p. 81.

14. International Conference on Population and Development (ICPD) Programme of Action of the International Conference on Population and Development, Report of the International Conference on Population and Development, September 5–13, 1994, UN Doc. No. A/CONF.171/13 (October 18, 1994).

15. Report of the Fourth World Conference on Women, September 4-15, 1995, UN Doc. No. A/CONF.177/20 (1995).

16. S. Tamale, *African Sexualities*: *A Reader* (Capetown: Pambazuka Press, 2011), p. 315.

17. C. Zampas, and J. Gher, "Abortion as human right - International and regional standards," *Human Rights Law Review* 8/2 (2008), p. 252.

18. R. Thomas, S. Kuruvilla, R. Hinton, et al., "Assessing the impact of a human rights-based approach across a spectrum of change for women's, children's and adolescents' health," *Health and Human Rights Journal* 17/2 (2015), p. 13.

19. Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa adopted 11 July 2003, entered into force November 25, 2005.

20. African Commission on Human and Peoples' Rights, "General Comments on Article 14 (1) (d) and (e) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa," (2012). See M. Geldenhuys, C. Kaufulu- Kumwenda, S. Nabaneh, and K. Stefiszyn, "The African Women's Rights Protocol and HIV: Delineating the

African Commission's General Comment on articles 14(1)(d) and (e) of the Protocol,"14(2) *African Human Rights Law Journal* 14/2 (2014), pp. 681-704.

21. African Commission on Human and Peoples' Rights 'General Comment No.2 on article 14(1)(a), (b), (c)and(f) and Article 14(2)(a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa' (2014).

22. C. Ngwena, E. Amissah-Brookman, and P. Skuster, "Human rights advances in women's reproductive health in Africa," *International Journal of Gynecology and Obstetrics* 129/2 (2015), pp. 184-187.

23. Art 19 of the Vienna Convention on the Law of Treaties (1969) 1155 UNTS 331.

24. H. J. Steiner and P. Alston, *International human rights in context: Law, politics, morals: Text and materials*, 2nd edn, (Oxford: Oxford University Press, 2000) pp. 1125-1126.

25. C. G. Ngwena, "Inscribing abortion as a human right: Significance of the Protocol on the Rights of Women in Africa," *Human Rights Quarterly* 32 (2010), p. 783.

26. S. Nabaneh, "The impact of the African Charter and the Maputo Protocol in The Gambia," in V. Ayeni (ed), *The impact of the African Charter and Maputo Protocol in selected African States*, (Pretoria: Pretoria University Law Press, 2016), p. 77.

27. On a discussion of Jammeh using Islam as a political tool, see, M. Darboe, "Gambia," African Studies Review 47/2 (2004), pp. 73-82.

28. H. Forster, Executive Director, African Center for Democracy and Human Rights Studies (ACDHRS), Email, June 24, 2019.

29. F. Viljoen, "An introduction to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa," *Washington and Lee Journal of Civil Rights and Social Justice* 16/11 (2009), p. 4

30. Nabaneh (see note 26), pp. 77-78.

31. "Women's Bill finally passed," *The Point* (April 15, 2010). Available at http://thepoint.gm/africa/gambia/article/womens-bill-finally-passed.

32. Guttmacher Institute, "Factsheet: Abortion in Africa," (2018), p.1. Available at https://www.guttmacher.org/sites/default/files/factsheet/ib_aww-africa.pdf 1. See also Guttmacher Institute, *"Abortion Worldwide 2017: Uneven progress and unequal access,"* (2018). Available at https://www.guttmacher.org/report/abortion-worldwide-2017.

33. L. Hessini, "Abortion and Islam: Policies and practice in the Middle East and North Africa," *Reproductive Health Matters* 15/29 (2007), p. 76.

34. C. Albertyn, "Claiming and defending abortion rights in South Africa," Revisya *Direito GV* 11/2 (2015), pp 429-454.

35. S. Nabaneh, "A purposive interpretation of article 14(2)(c) of the African Women's Protocol to include abortion on request and for socio-economic reasons," (LLM thesis, University of Pretoria, 2012), p. 34.

36. F. Banda 'Blazing a trail: The African Protocol on Women's Rights comes into force' (2006) 50 *Journal of African Law* (2006) 76.

37. Frontline Defenders, "Case history: Isatou Touray." Available at https://www.frontlinedefenders.org/en/case/case-history-isatou-touray#case-update-id-4294.

38. Gambia Bureau of Statistics (GBOS), "2013 Population and Housing Census: Youth Report' (2013) Vol 15, p.3.

39. Gambia Bureau of Statistics (GBOS), "2013 Population and Housing Census: Gender Report," (2014), pp. 15-16.

40. Gambia Family Planning Association, "Unsafe abortion in The Gambia," *African Journal of Fertility, Sexuality and Reproductive Health* 1/1 (1996), pp. 56-57.

41. Ministry of Health and Social Welfare, "National Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) Strategic Plan 2017-2021" (2017), p.6.

42. Ministry of Health and Social Welfare, National Family Planning Policy 2019- 2026 (2018) 15; Family Planning 2020, "FP2020 Core indicator summary sheet: 2017-2018 annual progress report on The Gambia," (2018). Available at https://www.familyplanning2020.org/sites/default/files/Gambia%202018%20CI%20Handout.pdf.

43. Gambia Bureau of Statistics (GBOS), "The Gambia 2013 Demographic and Health Survey," (2014), p.53.See, TT Kane, R. De Buysscher, T. Taylor-Thomas, et al., "Sexual activity, family life education, and contraceptive practice among young adults in Banjul, The Gambia," *Studies in Family Planning* 24/1 (1993), pp50-61.

44. M. Anyanwu and B.W. N. Alida, "Uptake of long-acting reversible contraceptive devices in Western region of The Gambia," *African Health Sciences* 17/2 (2017), pp. 409-417.

45. S. Nabaneh 'The unspoken: Unsafe abortion in The Gambia and the necessity for legal reform,' *AfricLaw* (March 13, 2018). Available at https://africlaw.com/2018/03/13/the-unspoken-unsafe-abortion-in-the-gambia-and-the-necessity-for-legal-reform/.

46. A. Glasier, A. M. Gülmezoglu, G. P. Schmid, C. Garcia Moreno, et al, "Sexual and reproductive health: a matter of life and death," *Lancet* 368 (2006), p. 1603.

47. Nurse participant at the National Coalition Meeting on Sexual and Reproductive Health & Rights, Banjul, The Gambia, May 4, 2019.

48. Gambia Bureau of Statistics (GBOS), "The Gambia 2013 Demographic and Health Survey," (2014), p. 246.

49. UNFPA, "Country programme document for The Gambia," DP/FPA/CPD/GMB/8 (2016), para 3. M. Lowe, D.R. Chen, and S.L. Huang, "Social and cultural factors affecting maternal health in rural Gambia: An exploratory qualitative study," *PLoS ONE* 11/9 (2016), pp. 116.

50. S. K. Brown, "Most common women's reproductive health problems in the gynecology ward of the Royal Victoria Teaching Hospital, Banjul, The Gambia," Research report (2011), p. 14 https://pdfs.semanticscholar.org/45a8/d493dd7acbdc354e96dad501238dbe4c3114.pdf.

51. Health Management Information System, "2018 Health Service Statistics Report," (Ministry of Health, 2019), p. 22.

52. Interview with Obstetrician & Gynecologist, May 9, 2019.

53. Information obtained from researcher based in the Ministry of Health and Social Welfare, May 4, 2019.

54. Human Rights Committee, "Concluding observations: The Gambia;" U.N Doc. CCPR/CO/75/GMB (2004), para 17.

55. UN Committee on the Rights of the Child (CRC), "Concluding observations on the combined second and third periodic reports of the Gambia," U.N Doc. CRC/C/GMB/CO/2-3 (2015), para. 63(a).

56. CEDAW Committee, "Concluding observations on the combined fourth and fifth periodic reports of The Gambia," U.N Doc. CEDAW/C/GMB/CO/4-5 (2015), para. 37(e).

57. Human Rights Committee (see note 55), para 18(a).

58. Nabaneh (2016, see note 26), p. 87.

59. Gambia Government, "Combined Report on the African Charter on Human and Peoples' Rights for the Period 1994 and 2018 and initial report under the Protocol to the African Charter on the Rights of Women in Africa" (2018). Available at http://www.achpr.org/files/sessions/64th_os/state-reports/2nd-1994-2018/gambia_state_report_1st_eng.pdf.

60. Ibid., p. 147.

61. Human Rights Council, "National report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/2: Gambia," U.N. Doc. A/HRC/WG.6/34/GMB/1 (August 22, 2019), para 61.

62. G. Kane, "Abortion law reform in Latin America: Lessons for advocacy," *Gender and Development* 16/2 (2008) pp. 361-375; G. Tadele, H. Haukanes, A. Blystad, and K.M. Moland, "An uneasy compromise': strategies and dilemmas in realizing a permissive abortion law in Ethiopia," *International Journal for Equity Health* 18/138 (2019), pp. 1-13; A.C. Sharma, J. Dhillon, G. Shabbir, and A. Lynam, "Notes from the field: political norm change for abortion in Pakistan, Sexual and Reproductive Health," Sexual and Reproductive Health Matters 27/2 (2019), pp. 1-7.

63. Sexual and Reproductive Rights Network, "Report on the National Coalition Building Meeting on Sexual and Reproductive Health and Rights," (May 4, 2019). (on file with author).

64. Women's Bureau "Position paper on constitutional review (Gender perspective)" (2019) (draft on file with author).

65. For other examples of this approach in other countries, see, M. Berer, "Abortion law and policy around the world: In search of decriminalization," *Health and Human Rights Journal* 19/1 (2017), p. 22.

66. Ibid., p. 19.

67. Albertyn (see note 34).

68. General Assembly Resolution, "Transforming our world: the 2030 Agenda for Sustainable Development," U.N. Doc. A/RES/70/1 (September 25, 2015); African Union, "Agenda 2063: The Africa we want" (2013).

Preventing State Harassment of Abortion Providers: The Work of the Legal Support Network in Latin America and East Africa

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Abstract

Access to safe abortion care is threatened, especially in legally restrictive settings, when providers are harassed or prosecuted on spurious charges. Legal networks have been working with safe abortion providers in Latin America since 2006, and in East Africa since 2010, to short-circuit this intimidation and protect access to quality information and abortion care. Planned Parenthood Global has nurtured these networks, now operating in nine countries. This paper describes this unique, prevention-focused legal strategy, with an eye toward analyzing its effectiveness, sharing the model and lessons learned with an interested audience, and encouraging replication. Prevention-focused legal networks for abortion providers have been effective in reducing police harassment, offering providers the information and skills they need to stand up to intimidation, and keeping safe abortion services available to those who need them. In the few cases of prosecution, providers have access to competent defense counsel through the networks. This model has also enabled better coordination between advocacy efforts on behalf of abortion rights, empowered health care providers, and increased access for women. Providers in other countries might explore whether and how creating local legal networks would offer similar protections.

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Introduction

Abortion in Latin America is subject to a patchwork of legal restrictions, ranging from total bans—even to save the life of a pregnant woman—to legal for any reason during the first trimester. Most countries in the region fall somewhere in the middle of this spectrum, with abortion permitted to protect the life and health of the pregnant woman, in cases of rape, and when the fetus will not survive once born.[1] Similarly, abortion laws in many countries in East Africa restrict access except to protect women's lives and health, though the Kenyan Constitution potentially expands access "if permitted by any other written law."[2] The Ugandan Constitution also prohibits abortion "except as may be authorised by law."[3]

In both regions, women are unable to freely make choices regarding their bodies, particularly when it comes to reproduction. Although such decisions ought to be in the hands of the woman whose life will be affected, other people—often health care professionals and justice officials—hijack the decision-making process and eviscerate the woman's power to decide, making decisions based on their own personal, moral, and religious beliefs and knowledge. Exacerbating this denial of autonomy, state agents ignore or dismiss the effects of unwanted and unsafe pregnancies on the health of women, employing a narrow interpretation of the right to health. The result is consistent, region-wide violations of the rights of women in both Latin America and East Africa: violations of the right to health, to access to justice, to being treated with dignity and impartiality, and, above all, to exercising their sexual and reproductive rights—a cornerstone of fundamental human rights.

In this context, private health care providers in these two regions constitute an avenue for women to exercise their rights and access the health care they need. However, the complexity of legal frameworks, together with the pressure exerted by religious and other cultural forces, means that private health care providers face obstacles and risks to providing high-quality, comprehensive care. As a consequence, private abortion providers are harassed by the police, forced to respond to spurious charges, and, occasionally, arrested and prosecuted.[4] And with access to safe care restricted, women resort to unsafe services—resulting in thousands of deaths and injuries each year—or are forced to carry unintended and unwanted pregnancies to term.[5]

Preventing this kind of police harassment and abuse demands the radical transformation of gender norms. But as that work continues, such harassment and persecution *can* be short-circuited in the immediate term. Abortion providers and lawyers in nine countries in East Africa and Latin America have, over 10-plus years of trial and error, developed effective protection strategies. These strategies are implemented by national legal support networks. Refined together with Planned Parenthood Global, the Legal Support Network (LSN) model has enabled and empowered providers to offer care—and clients to receive care. The LSN provides training and other opportunities for local lawyers to develop professionally and to help those who provide sexual and reproductive health services fully understand their rights and duties. Likewise, the LSN facilitates the exchange of experiences among lawyers within and between countries and regions to share lessons learned and improve the way they work.

Origins of the Legal Support Network

The work of Planned Parenthood Global is grounded in human rights, seeking to ensure access to sexual and reproductive health services, advocating for progressive laws and policies, and fostering social norms that uphold health equity and healthy sexuality. This has included supporting health care organizations in providing abortion care to the full extent of national law and consistent with the human rights to life, health, bodily autonomy, and information.

In 2000, Planned Parenthood Global facilitated the creation of a Latin American abortion providers' support network to combat the isolation of community-based and feminist partner organizations dedicated to providing abortion services under severely restricted legal circumstances and in politically difficult and dangerous situations. Under very hostile conditions, providers in these

organizations offer high-quality, client-centered services for those women most at risk of seeking unsafe procedures. This network provides a forum in which critical mutual support can be lent to those working in such harsh environments and offers an opportunity for the exchange of information and expertise.*

At the request of members of this network, Planned Parenthood Global partnered with the ESAR Foundation, a Latin American organization working in sexual and reproductive health care services, to create the LSN in Latin America in 2006. Then, in 2011, based on lessons learned from Latin America, Planned Parenthood Global and its partners extended the LSN model to East Africa, where member lawyers work not only with Planned Parenthood Global partner organizations but also with providers trained and supported to provide comprehensive abortion care by sister nongovernmental organizations.

What the Legal Support Network does

The LSN is guided by human rights, especially sexual and reproductive rights. Its members are committed to the belief that people have the right to autonomy over their own bodies, to make informed decisions about whether and when to have children, and to access the information and health care needed to make those decisions a reality. Its mission is to ensure that providers are able to offer abortion care and their clients are able to receive care with dignity and without fear.

The LSN endeavors to minimize the legal risks and ensure the legal protection of the rights and safety of providers and users of abortion care primarily by implementing legal guidelines for risk prevention. Through periodic exchanges during regular visits, in-country meetings, and regional gatherings, providers and local lawyers are able to share lessons learned, identify trends and solutions, and establish trust. The network also offers ongoing support and monitoring to private providers who have been trained in Planned Parenthood standards; trains and prepares lawyers to defend private providers, if necessary; and facilitates links with advocacy groups and provides "lived experience" for local advocacy initiatives to advance abortion rights. This unique model allows women who are making important decisions about their own sexual and reproductive health to benefit from access to sensitized health personnel and sustainable services.

In practical terms, the LSN contributes to protecting access to safe abortion in four ways: prevention, risk reduction, defense, and advocacy.

Prevention

Preventing the harassment and arrest of abortion providers is at the heart of the LSN model. This is because the stigmatization of abortion, regardless of what the law formally permits, leaves providers vulnerable to intimidation and fearful of fighting back. And, in the absence of grounds for prosecution for the actual provision of care, harassment often focuses on trying to detect failings in the administrative requirements for practice—for example, authorizations, documentation, or employment laws and procedures. To protect providers from harassment by police and spurious prosecution, and to ensure that women have ongoing access to quality information and health care, local lawyers work on a regular basis with providers to put a wide range of protection mechanisms in place. These include the following:

- ensuring the security of clinic premises, staff, and documents (client registries, clinical records, and financial data)
- compiling and maintaining a complete and up-to-date file of credentials, authorizations, certificates, tax records, and any other documentation required to operate legally
- instituting clear and comprehensive counseling and informed consent procedures
- training all staff in rights-based approaches to health care
- confirming compliance with all relevant labor laws
- establishing procedures in case of both medical and legal emergencies.

These protection mechanisms are established through periodic visits with providers, during which the lawyer clarifies doubts the provider may have about the law and regulatory and administrative requirements, reviews the provider's compliance with security measures, and offers any needed assistance in implementing suggested changes.

Risk reduction

When providers find themselves facing any incident that involves the law—such as a raid, police harassment, accusations, or prosecution—a local LSN lawyer works with the provider and the LSN secretariat to manage the incident and reduce the risk to the provider, clinic staff, and clients. Most incidents of harassment by police or other authorities are abuses of power, driven by ideology or corruption and not the law. As a result, most incidents fizzle out before the provider gets anywhere near court, before services are shut down, and before clients are left without the health care they need. The main point is that each incident must be managed to ensure that it does not spiral out of control. The LSN lawyer's first step in case of a legal incident is to provide guidance to the provider to prevent circumstances from deteriorating. As part of this process, the lawyer interviews and counsels clients and staff who may have been present or otherwise involved in an incident.

Crucially, the lawyer consults with a cross-regional advisory committee for strategic guidance and support. The committee is composed of lawyers and health care providers who are able to draw on their experience working regionally and globally, as well as their expertise in international human rights, national law, and reproductive health. This "war room" undertakes legal and medical analyses of cases, formulates risk reduction, and (when necessary) devises defense strategies, including preparation for the unlikely event of prosecution.

Defense

Because the LSN's prevention work is so thorough, interactions between providers and the judicial system do not often reach the point where a defense strategy is necessary. But if a legal incident deteriorates and a defense is needed, the LSN lawyer serves as the provider's advocate before the Ministry of Health, police, other local officials, the media, and courts.

Working from an incident report, the lawyer and provider continue to consult with the advisory committee on a defense strategy. When a prosecution does move forward, the LSN lawyer and the committee work together to implement the defense strategy that has been developed.

Advocacy

Through their work, LSN members serve as advocates, individually and collectively, for the full range of reproductive rights in their countries and regions. When appropriate, they also leverage and draw from their work protecting and defending providers to support advocacy to influence public policy, including advocating for laws and regulations that advance reproductive rights broadly and abortion rights specifically.

Although LSN lawyers are on the frontline of ensuring that women are not denied care to which they are entitled, public advocacy takes a back seat to their prevention work. That said, they are a vital source of data for supporting advocacy strategies and emblematic legal cases, and they may move forward on advocacy campaigns at the direction of the secretariat and under the leadership of local advocates.

To carry out activities in these four domains, the lawyers participate in ongoing skills building—such as trainings, meetings, and webinars—aimed at strengthening their technical capacity; keeping them up to date on developments in the policy environment and medical field; and nurturing their solidarity with the network, with providers, and with the community of people who need care. In addition, they enjoy access to professional development opportunities in the form of national, regional, and international conferences, as well as LSN-specific events. Finally, they occasionally engage with the wider reproductive rights movement

around the world, which offers opportunities for both intellectual and professional growth.

LSN management

In Latin America, Planned Parenthood Global works jointly with Fundación ESAR and serves as the LSN secretariat. Planned Parenthood Global developed the LSN model and drafted the tools and protocols used by the lawyers to prevent harassment of their clients. And it continues to raise money from donors to support this work. In East Africa, a local human rights organization has adapted the model and serves as secretariat in each of the three countries where the LSN operates. In both regions, the secretariat identifies, vets, and selects LSN lawyers; devises training and networking opportunities; troubleshoots (including participating in the advisory committee "war room"); and provides moral, intellectual, and financial support to LSN members.

Measuring what is not there: The impact of the LSN

Because it is hard to measure incidents that have *not* happened, the value of prevention is often underestimated and neglected. But the success of prevention in protecting vital services makes it the heart of the LSN model and is what distinguishes it from most legal work in the reproductive rights sector. In one country, for example, the LSN was contacted about a case concerning a minor girl who had become pregnant as a result of sexual violence perpetrated by her father. Instead of turning away this complicated case, the organization was able to get the legal support necessary to navigate the burdensome reporting requirements for sexual violence, and the timing and management of services, to ensure that all documentation was completed according to the law. The end result was that the girl was able to receive the services needed and the provider was able to work with authorities to support her charges against the aggressor.

In the more than 12 years since the LSN's creation, close to 100 local lawyers have been trained, 75% in East Africa and 25% in Latin America. More than 40 partner organizations and more than 400 independent providers have received support, training, or protection from LSN lawyers.

In this time, 30 legal cases have been brought against providers. Of these, only seven cases have reached the courts (all in East Africa), and all seven have had favorable outcomes, which of course in turn means the women they serve continue to receive vital services from a safe source. LSN lawyers prevented the other 23 cases from reaching the courts.

But the network's most important impact has been to protect urgently needed health care: since 2006, nearly half a million people have received safe abortion care from partners protected by the LSN. While not a permanent solution to legal restrictions and gender discrimination, LSN strategies do preserve and expand access by short-circuiting harassment and have proven to be effective in ensuring that women are able to realize their rights.

The LSN has contributed to keeping harassment to a minimum in the countries where it functions in Latin America and East Africa. In the few cases of prosecution, providers have had access to competent defense counsel through the network. In one emblematic example, a provider organization working in a provincial area endured low-level harassment from local authorities for years. LSN lawyers supported the provider through attempts at police extortion, defamation, and spurious inspections. When a woman presented at the organization with severe hemorrhaging, the staff immediately transferred her to the local hospital, only to encounter harassment from the hospital staff and then accusations of performing an illegal abortion. The LSN lawyer ensured that the charges did not move forward—and the charges were indeed ultimately dropped. This provider organization continues to thrive and serve as a principal provider of sexual and reproductive health care in its geographical region.

Lessons learned

It has taken more than a decade of trial and error to create a successful LSN in the two regions concerned, and Planned Parenthood Global continues

to work alongside colleagues and partners to refine and strengthen the model. Through those experiences, important lessons have been learned along the way, including the following.

Prevention is the heart of a successful LSN.

Defense and advocacy are vital roles for human rights lawyers. The LSN lawyers do both, but—within the LSN—their primary role is to prevent harassment, abuse, and spurious prosecution of abortion providers. This ensures that people have the ability to exercise their reproductive rights within the limits of national legal frameworks. This focus on prevention is what makes the LSN model unique and, more importantly, successful in enabling health care providers to go about their work with minimal disruption.

Fostering a prevention mindset in LSN lawyers can be challenging at the start. It demands opportunities to discuss fears related to the work, personal values, and myths around sexuality. It also requires developing a solid shared understanding of the national legal framework and how providers' work fits into both national laws and international human rights norms.

Expertise in compliance, not in leading the charge, is what is needed most.

The most helpful lawyers in the LSN are generally not litigators or constitutional scholars. This sometimes comes as a surprise to the reproductive rights community since so much legal work to advance reproductive rights entails challenging constitutionality, clarifying laws, domesticating international human rights norms, demanding remedies, and litigating. The LSN serves another purpose, however: to prevent harassment and ensure the continuity of urgently needed services. As such, providers need lawyers that can help them navigate the regulatory and administrative requirements of their profession. The LSN looks for lawyers with expertise in such disciplines as labor law, tax law, and contracts.

Quality, comprehensive counseling is the best prevention strategy.

Planned Parenthood Global learned early on that incidents arose as a result of clients not having received full preparation and information. Taking the time for comprehensive counseling and informed consent procedures that fully explain pregnancy options, the abortion procedure, what to expect during and after an abortion, and what to do in case of any concerns or an emergency is the best way to ensure that women are fully able to exercise their rights to information and accessible, high-quality sexual and reproductive health care. This thorough understanding also helps protect against legal risk.

Solid local legal analysis should be coupled with human rights standards.

Providers and lawyers rely heavily on guidance documents that offer strong analysis of local legal frameworks but that are also informed by human rights law. In the early days, the Latin America LSN turned to international human rights lawyers to analyze the national legal context and draw up frameworks that could help guide providers. Now each country network has an internal human rights-grounded legal framework or reference guide that responds to national needs. The results are nuanced, useful documents that can be updated as needed.

Never ignore building productive relationships.

In the early days of the LSN, Planned Parenthood Global introduced lawyers and providers to one another and simply expected that they would work well together. After all, providers asked for legal support, and the lawyers submitted to a rigorous process of selection. The organizers learned that this was not the case, however. Lawyers overreached their authority, attempting to tell providers what to do, and refusing to continue to support them when they did not comply. Providers, for their part, in moments of crisis, simply turned to lawyers they knew or contacted Planned Parenthood Global directly rather than reaching out to the trained LSN lawyers. In response, Planned Parenthood Global and the secretariats actively encouraged providers and lawyers to develop relationships of collegiality and mutual respect through regular visits and joint

meetings. Lawyers began to understand that their purpose was to provide guidance, advice, and support, and that providers sometimes did not follow their recommendations for sensible reasons. Meanwhile, providers started to see that the LSN lawyers knew what they were doing and were there to help, not create senseless paperwork.

Retaining talented lawyers is hard.

After a lawyer has joined the LSN, it can be a challenge to encourage them to remain. Because LSN members' work is sporadic and because budgets do not allow for paying salaries, the network has always used volunteer lawyers. This has been both a strength of the model and a challenge. The strength comes from knowing that, as volunteers, lawyers have a serious commitment to reproductive rights and to abortion rights in particular. But there have been challenges in keeping lawyers engaged in the network over the long haul. In the absence of a salary, the LSN secretariats have identified creative ways to compensate and engage LSN members. This includes paying the lawyers on a fee-for-service basis for the prevention, risk reduction, and defense work that they do. In addition, the LSN offers professional development opportunities to its members, including ongoing training, participation in national and regional conferences, and more informal webinars and other learning spaces.

The importance of light-touch management.

Over-involvement of the managing secretariat in day-to-day activities is a risk for any network structure. During the first few years of the LSN, Planned Parenthood Global closely monitored the work of both the lawyers and the providers. But Planned Parenthood Global realized over time that setting out clear expectations, ensuring that members of both networks had the tools they needed, and checking in regularly on progress and setbacks made for a higher-functioning team. This "light-touch" management has strengthened the autonomy of the lawyers, deepened their commitment to the network and its mission, and freed up both the lawyers and secretariat staff to clarify and focus on their primary responsibilities rather than on each other.

Recommendations

Prevention-focused legal networks for abortion providers are effective in reducing police harassment, offering providers the information and skills they need to stand up to intimidation, and keeping safe abortion services available to those who need them. Providers in other countries might explore whether and how creating local legal networks would offer similar protections. Planned Parenthood Global would welcome engaging with interested groups, who are invited to contact the corresponding author.

* To protect the security of these providers, their staff, and their clients, this article does not share specific examples of harassment and abuse.

References

1. Center for Reproductive Rights, *The world's abortion laws 2019*. Available at http://www.worldabortionlaws.com.

2. Constitution of Kenya (2010), art. 26(4).

3. Constitution of the Republic of Uganda (1995), art. 22(2).

4. T. Padgett, "Anti-abortion extremists: Look first at Latin America's dark, dangerous path," *WJCT* (May 15, 2019). Available at https://news.wjct.org/post/anti-abortion-extremists-look-first-latin-americas-dark-dangerous-path.

5. Guttmacher Institute, *Abortion in Latin America and the Caribbean*. Available at https://www.guttmacher.org/fact-sheet/abortion-latin-america-and-caribbean.

Denial of Safe Abortion to Survivors of Rape in India

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Abstract

Access to abortion is desperately needed when pregnancy is the result of rape, both within and outside marriage, and especially when a girl has been raped. The availability of services remains highly restricted because of the way abortion providers interpret the law. This paper presents the experiences of 40 rape survivors, including two children, denied an abortion following rape. The cases were recorded by CEHAT (Centre for Enquiry into Health and Allied Themes) in the course of building capacities of public hospitals to respond to violence against women in Mumbai, India, since 2000. We found that enormous damage is inflicted on women and girls by misinterpretation of the laws on abortion and rape, combined with a lack of understanding of the serious damage rape does, particularly repeated rape, and alongside other forms of assault and abuse. Domestic laws in India place a clear legal responsibility on health professionals to offer immediate care and treatment to rape survivors, including timely access to abortion. It is past due time for both the government and the courts to begin to hold themselves and health professionals accountable for ensuring this care is provided.

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Introduction

India has passed several laws that recognize the right to health care for survivors of domestic and sexual violence. These include the Protection of Women from Domestic Violence Act (PWDVA) 2005, the Protection of Children from Sexual Offences Act (POCSO) 2012, and relevant clauses on sexual violence in the Criminal Law Amendment Act 2013.[1] As a response to overwhelming evidence showing that India's health systems mistreat rape survivors, the latter two laws mandate that public and private hospitals provide immediate treatment for survivors of sexual violence. They also mandate punishment for failure to do so.[2]

The POCSO 2012 requires that all registered medical practitioners render emergency medical care to attend to the needs of children who have been raped, including access to abortion. That the immediate treatment for survivors of rape must include emergency contraception and abortion services has also been clearly mentioned in policy guidelines issued by the Ministry of Health and Family Welfare in Guidelines and Protocols for medico-legal care for survivors/victims of sexual violence.[3] In reality, however, rape survivors who become pregnant, both girls and women, face procedural gaps and a range of barriers in accessing abortion services.

This paper presents the experiences of 74 people (72 women and 2 children) who had been raped and who sought an abortion. Fifty-five of the women sought an abortion before 20 weeks of pregnancy, and 19 women and the two children did so after 20 weeks. None of those who sought an abortion after 20 weeks of pregnancy was able to have an abortion, not even the two children, even though they followed the procedure for seeking permission from a high court to do so. Of those who sought an abortion before 20 weeks, which should have been granted without delay or question, only 36 of the 55 were able to have an abortion.

The paper concludes by suggesting ways of ensuring easier access to abortion for rape survivors.

Barriers preventing rape survivors from accessing abortions

CEHAT (Centre for Enquiry into Health and Allied Themes) is a Mumbai-based research institute that has been working on health and human rights since 1994. As part of our program on violence and health, we have worked closely with hospitals in Mumbai since 2000 to improve their responses to violence against women and help them build their capacity to provide psychosocial support to survivors and their families. This entails ongoing training of health providers, counselors, and direct intervention services for women who have experienced violence. This work puts us in close contact with other parts of the public health system, including abortion service providers, and gives us the opportunity to understand the barriers women face when they seek abortions after rape.

Experiences described in this paper come from three sources of data gathered by CEHAT during the course of our work:

- A study conducted by CEHAT in two antenatal departments of public hospitals where we asked all the women about their experience of domestic violence and offered counseling services.[4] Of the 142 women who disclosed abuse in their marriages and consented to the counseling intervention, 31 reported that their current pregnancy was the result of rape by their husbands. All 31 sought abortions. Of these, 24 women were less than 20 weeks' gestation but only five of them were able to have an abortion. Of the rest, the 19 women who were less than 20 weeks and the seven who beyond 20 weeks were all forced to continue their pregnancies.
- The service records of crisis intervention services provided by CEHAT to survivors of sexual violence at three public hospitals from April 2008 to March 2015.[5] Of the 728 women who received these services, 43 reported becoming pregnant as a consequence of rape. Of them, 31 were within 20 weeks of gestation and received abortions, while 12 who had sought abortions after 20

weeks of pregnancy were refused.

- Legal interventions initiated by CEHAT in two cases of child rape where pregnancies were discovered only after 20 weeks of gestation. An appeal was made to the High Court and the Supreme Court for permission to terminate the pregnancies.[6]

The women in the public hospitals who had disclosed rape by their husbands reported that health care providers imposed the following barriers, which in many cases led to the denial of abortion services in the hospital.

1. Abortion refused because it was their first pregnancy

These women were told that abortion may cause secondary infertility, and that it may be a threat to their lives. Even though CEHAT provided factual details that contradicted their claims of such risks, the health care providers insisted on what they said and reiterated that abortion was a risk they would not allow.

2. Misinformation about medical abortion pills

Women who reported in an early stage of pregnancy and requested medical abortion pills were turned away. Providers said the pills may cause life-threatening bleeding, and that excessive bleeding would necessitate a surgical intervention anyway. In fact the mifepristone-misoprostol combi-pack is approved by Drug Controller General of India for use up to 63 days of gestation.[7]

3. Abortion offered only if woman agreed to contraception or sterilization

Women with two or more children were told that abortion would be provided only if they consented to sterilization to prevent future pregnancies or accepted a Copper-T IUD after the abortion. The abortion law does not mention such conditions, though contraception is provided if the woman herself wishes it. These conditions are a form of medical abuse, however, with a long history in India. They arise from the country's population control policies, which were and often still are enforced with little regard to human rights.[8]

4. Insistence on spousal consent

Spousal consent for abortion is the greatest barrier for women seeking abortion services. Despite the fact that the law clearly states that the providers need only have the consent of the adult (married) woman, several providers insisted on the husband's consent or authorization. It is only in the case of a minor (less than 18 years of age) that parental or guardian consent must be obtained. This is a critical issue for survivors of marital rape because the husband may well want to exercise control over whether the woman can have an abortion.[9] Several of the women in the antenatal clinic reported having disclosed spousal abuse to their doctors, who continued to insist on the husband's consent, ignoring the woman's difficult situation. This is rooted in patriarchal notions about a husband's role as decision maker, as well as a defensive practice by doctors, who claim that a husband may challenge them for proceeding with a termination without his permission. Two women in the antenatal clinic reported the following experiences.

> *N., age 25, was eight weeks pregnant. Her husband had been physically and emotionally abusing her throughout their four-year marriage. She did not want to continue with the pregnancy, but the doctor insisted on her husband's signature, even after she disclosed the abuse. Having got the husband's permission, the doctor went on to ask her to get a no-objection certificate from the police, that is, permission from the police to allow the abortion.*

The doctor's demand was totally baseless.

> *M. had filed for divorce after having endured her husband's violence for over 15 years. She was living separately from him and had her child with her. The husband would barge into her house and rape her. When she discovered that she was pregnant, she sought an abortion. The doctor insisted that she either get her husband to consent or produce a divorce decree. She was able to have an abortion only after reporting the matter to the higher*

authorities at the hospital.

5. Insistence on D&C for abortion, requiring an overnight hospital stay

Many Indian abortion providers continue to use dilation and curettage (D&C) as the method of abortion no matter the length of pregnancy. This method is no longer recommended by the World Health Organization or the Indian Ministry of Health and Family Welfare guidelines because it requires general anesthesia and an overnight stay, and far safer and less invasive methods are available.[10] Indian doctors continue to recommend it and also insist on using it; D&C may be the only method they know, and they consider it to be the most reliable and safe method. This is more than just an issue of abortion method; it has an important bearing on women's access to abortion. Any method that requires a hospital admission makes it difficult for women to conceal that they are having an abortion; extended family may come to know about it, thereby threatening loss of privacy and confidentiality. These are both critical for women accessing abortion care, especially if they do not want an abusive husband to know they are having an abortion.

The following two case histories are among the worst that the CEHAT team has encountered in its interaction with women in one of the public hospitals.

Insistence on delaying abortion to do a D&C despite negative social consequences for the woman. A young woman survivor of spousal violence who was 11 to 12 weeks pregnant asked for an abortion at the earliest possible time. She had come to the hospital after she had missed her periods for two months and discovered that she was pregnant. As she was experiencing severe physical and sexual abuse from her partner, she did not want to proceed with the pregnancy. No one in the family knew about the pregnancy and she therefore wanted to end it as soon as possible. She managed to get her mother to come to the hospital with her, as a relative was required to give consent for a surgical procedure. However, the doctor told her to come back four weeks later for the abortion. The woman went to the counselor at the hospital-based crisis center and told her this. She was afraid that in four weeks her baby bump would be visible, and everyone would know she was pregnant. The counselor intervened and was told by the doctor that the "surgical procedure" was easier and safer after 16 weeks (this is often said about D&C), that she was only trained to do abortions after 16 weeks, and that the fetus was very small prior to 16 weeks so it was harder to carry out the procedure.

The counselor intervened by speaking not only to the treating doctor but to other more senior doctors. The woman was only able to have an early abortion when the senior doctors overruled the treating doctor.

Delaying an abortion on medical grounds and jeopardizing the woman's health and life. A 31-year-old woman in an increasingly abusive marriage sought help from the hospital-based crisis center in filing a case for maintenance and divorce. She also wanted to file a police report so that her husband could be arrested immediately. However, the police did not record the complaint, but called her husband into the police station, where they threatened him and sent both of them home. A month later, the woman came back to the crisis center following a visit to the hospital gynecology department for an abortion. She told the counselor that she did not want the child at all, but the doctor told her she did not have "enough blood" (she was anemic), so an abortion could not be done. The doctor advised her to take iron tablets for a week and then come back for the abortion. She went back 10 days later, but the doctor still refused to do the abortion because she was still too anemic. At that point she was between six and eight weeks pregnant. The counselor spoke to the doctor about the urgency of the abortion. The doctor told the counselor that if after she had taken iron tablets once more, the hemoglobin levels still did not increase, they would give her a local anesthetic, and do the abortion with no further delay. She came back after two weeks and told the counselor that her community had found out that she was pregnant, as

she was by then visibly pregnant. The hospital was willing to carry out the abortion at this stage, but her family and neighbors were pressuring her to continue the pregnancy. She was completely distraught and felt forced to continue the pregnancy. She had a premature labor in her eighth month, resulting in a stillbirth. She had become very weak; her situation had worsened in the last three months and she could not go to work due to pregnancy and exhaustion. She continues to live with her abusive husband. Thus, a woman who had made up her mind to leave an abusive husband, despite all the pressures, felt forced to stay in the relationship and continue an unwanted pregnancy, while the delay in receiving an abortion had severe consequences for her health and life. The treating doctors in her case were simply unable to understand her social reality and why they needed to provide an abortion urgently.

Doctors may not provide abortions because the criminal law does not require abortion to be provided in cases of marital rape. Our findings show that many women who experience marital rape, both those living with their partners and those who are separated or divorced (who may still be raped by their partners), may be refused access to safe and legal abortion in spite of the law.

Yet there is global evidence of a strong positive association between women seeking an abortion, and violence and physical abuse (defined as slapping or beating) by husbands in the year previous to the abortion. Evidence reported from India in this multi-country study also indicated that women in violent relationships were more likely to have an abortion, as well as to experience violence after (and possibly because of) the abortion.[11]

Qualitative studies among women in several states of India found similar associations.[12] For example, in Tamil Nadu, qualitative interviews with 66 women and 44 of their husbands living in rural hamlets showed that non-consensual sex and sexual violence were strongly associated with the women having had an abortion and with their inability to use contraception effectively or to get their husbands' cooperation to abstain from sex as a way to space or prevent pregnancies. Both the women and the men in this study reported that it was the right of the husband to demand sex, regardless of what the wife wanted. Several respondents noted that especially if the husband was drunk, he might demand sex and refuse to use contraception. Women who objected to having sex or who wanted to use contraception were sometimes accused of sexual infidelity and were often beaten.[13]

Given this evidence, doctors need to recognize marital rape as a compelling reason for providing abortion services. Yet the law as it stands today only treats rape as a condition for which an abortion should be provided unconditionally if the rapist is not the woman's husband or former husband. Marital rape continues to be an exception under the criminal law, even though it has been recognized as a form of violence under the civil law since 2005 in the Protection of Women from Domestic Violence Act.

Barriers to abortion

Refusal of abortion in the public sector

The various barriers that women experience in seeking an abortion in the public health sector often push them to the private sector, if they can afford it, or to resort to unsafe abortions, which continue to be common in India. Data show that the majority of Indian women who have had an abortion report doing so at a private facility.[14] The only other option is to continue with an unwanted pregnancy. This makes them more vulnerable and unsafe if they are in an already abusive home situation.

Seeking abortion beyond the 20-week time limit

Seven women disclosed marital rape when we interviewed them at the time of their first antenatal registration at the public hospital, which was at 20 weeks of pregnancy. They did not attend the health facility earlier because their husbands were controlling their movement and forbid them to access the health service. None of the seven women wished to continue their pregnancy, but all of them were denied an abortion because the pregnancy was beyond the legal 20-week limit.

We additionally received 31 rape survivors at the crisis intervention centers located in three public hospitals. These women were raped by ac-

quaintances. Twelve of them were able to disclose rape only after the pregnancy had advanced to a stage when it was visible. Most of the perpetrators had threatened to harm their families and repeat the abuse if they told anyone about the attacks. All 12 women said their pregnancy was an outcome of the rape and pleaded for a termination. They too were denied abortion due to advanced gestational age, without any concern shown by the health professionals about the social consequences of continuing the pregnancy. When the CEHAT team engaged with the health care providers, they suggested the women could give the babies up for adoption once they were born, with no apparent awareness of the multiple impacts on the lives of women facing this situation.

Child survivors of sexual violence seeking abortion

Two cases of child rape survivors, one age 10 and the other age 13, received a lot of public attention in India recently.[15] In each case, the pregnancy was well beyond the 20-week legal limit when the child sought access to an abortion. The CEHAT team proactively intervened in both these cases at the level of the providers as well as in the courts. In the case of the 10-year-old, expert opinion from gynecologists, as well as a statement signed by three US gynecologists with expertise in third-trimester abortion—published by the International Campaign for Women's Right to Safe Abortion—were submitted to the Supreme Court. The opinions and statements underscored the need to terminate the pregnancy in the best interests of the child and to emphasize that a third-trimester abortion was not less safe than the alternatives.[16]

In the case of the 13-year-old, CEHAT's first intervention was an appeal to the provider to terminate the pregnancy under Section 5 of the MTP Act, which allows abortion when the life of the woman or girl is at risk. To authorize this, two medical opinions were required, but the provider referred the matter to the court. The 13-year-old child was initially taken to a private practitioner, as her parents were concerned that their daughter had gained so much weight. An ultrasound indicated that the child was 28 weeks pregnant. Due to the advanced gestational age, the medical provider sought the intervention of the Supreme Court as to whether to carry out a termination. The Supreme Court directed the state to set up a medical board and provide its opinion on a termination of pregnancy. The pregnancy was at 32 weeks when the Supreme Court ruled in favor of carrying out a procedure to terminate the pregnancy, citing grave mental trauma as the justification. But within a day or two of this verdict the child was already in labor and ended up delivering a live fetus.

The 10-year-old had been raped by her uncle. When her family realized she was pregnant, they immediately sought medical assistance so she could have a safe abortion. The hospital dated the pregnancy at 26 weeks. She and her family were referred to the district court to seek permission to undergo a termination. The district court directed the medical institute to set up a medical board to examine the child and provide an opinion on whether or not she could undergo an induced abortion. The opinion of the board was not made public except to confirm that the pregnancy was 26 weeks. The district court rejected the plea for abortion. The matter was taken to the Supreme Court of India, which requested a new medical board to provide a second assessment and an opinion. Re-examination of the child dated the pregnancy at 32 weeks. The board opined that carrying out a termination at that stage could be life threatening. The Supreme Court denied a termination of pregnancy. The child went on to deliver in a medical institution.

Obstacles in ensuring access to abortion for child survivors of rape

There are several reasons why pregnancies are already at an advanced stage when they are discovered; these became clear during our interactions with the girls and their families. To begin with, a child is very unlikely to realize that she is pregnant or that being raped could lead to a pregnancy. Hence, by the time one or more family members realize that something is not right, or that the child

is pregnant, there has already been a delay of several months; that is, until the pregnancy is visible. Slightly older children, who may recognize that they are pregnant, may fear that their family members will not believe them. This too may contribute to delay in going to a health facility. Other factors, such as fear from a threat by the abuser to her life or to her loved ones can also keep the child from disclosing the violence and its outcome. Thus, in many cases, a pregnancy is detected only when the child complains of nausea or abdominal pain, or when it is visible.

Role of the courts vis-à-vis authorizing abortions after 20 weeks

As is evident from the two narratives and similar reports that are appearing regularly in the media, the courts are being inundated with pleas from women and girls seeking their authorization for abortions after 20 weeks of pregnancy. But the courts find themselves in a difficult situation.17 This is because determining whether or not an abortion after 20 weeks should be allowed for a child or a woman is a matter of medical rather than legal judgment and hence not within their purview. Therefore, the courts have invariably ordered a medical board to be established to make the medical judgment. It is important to clarify here that the MTP Act makes no mention of the need or requirement of a medical board. This has been initiated by the courts and has now become the standard. These boards are expected to evaluate the physical and mental health condition of the pregnant child or woman, advise whether or not to provide a termination of pregnancy, and submit a written report to the court. Taking cognizance of several such cases that had reached the Supreme Court, the court directed the Ministry of Health and Family Welfare to instruct all the states in India to establish a permanent medical board in all tertiary medical institutes.[18] However, the medical boards in many cases appear to restrict their role to the interpretation of the MTP Act, instead of lending their expertise to assessing the extent of the physical and psychological trauma caused by the act of rape that led to the pregnancy.[19] Moreover, the members of any one medical board may or may not have expertise on or experience of abortion after 20 weeks of pregnancy, let alone at 28 or 32 weeks.

Hence, the opinions provided by medical boards in a number of cases in the past were well within the scope of the treating doctor's expertise, yet they took an average of four weeks to be assembled, examine the patient, and debate and return an opinion. Moreover, none of the medical boards' opinions that we have studied has raised concerns about the denial of abortion by the treating doctors despite the existence of Section 5 of the MTP Act. In fact, they did not even raise concerns about the mental trauma and anguish that survivors endure due to the delay in receiving a decision, let alone an abortion itself.

In an effort to garner support for access to safe abortion in these child pregnancies, medical opinions were sought from senior US-based gynecologists with expertise in carrying out third-trimester abortions.[20] In their letter of support, these doctors provided a comprehensive body of evidence suggesting how to safely perform a third-trimester abortion in a young child. Their letter outlines several safe procedures including use of a feticidal injection of digoxin or potassium chloride, followed by one or two days of gradual osmotic cervical dilation, and then induction of labor with misoprostol and/or oxytocin as the safest and most common way of carrying out the intervention. The letter also draws attention to the risks of continuing a pregnancy to term in children under the age of 18, citing a range of reasons, such as an under-developed uterus, narrow pelvic bones, cervix, and birth canal, and the increased risk of serious obstructed labor in a vaginal delivery, which could lead to maternal death. This evidence was made available to the medical board and was also placed on the record at the Supreme Court.

Yet, in the case of the 10-year-old, the medical board did not substantiate its claim that the continuation of pregnancy was safer for this child, who also suffers from a congenital heart condition and whose pelvic bones were under-developed compared to those of an adult woman. Despite being

doctors, they did not comment on the psychological impact of a pregnancy on the child in the aftermath of rape. It is therefore critical to stress that doctors appointed to these boards may have no expertise in provision of abortions beyond 20 weeks. Nor have we heard of any training for those who may serve on these boards, to acquaint them with safe abortion guidelines for late abortions and evidence of the negative impact rape has on the lives of survivors, which we can assume is worse in the case of a child.

Yet survivors of rape continue to be compelled to approach the Supreme Court or a High Court where the judiciary routinely refer the matter to a medical board. An analysis of 74 court cases where women or girls were seeking permission for termination of pregnancy is indicative of what is happening in India. These survivors all appealed to a court for a decision between June 1, 2016, and February 3, 2018. Of 74 rape survivors, 23 were denied an abortion based on the opinion of a medical board. What is even more disconcerting is that 13 of these 23 had reached the courts through a human rights lawyer, even when the pregnancy was less than 20 weeks. Of the 74, 39 were rape survivors (in all age groups); 18 of the 39 were denied an abortion.[21] The court's decisions appeared to be based solely on the opinion of the medical boards. The medical reports and expert opinions submitted by the petitioners (that is, the women themselves) were not considered. In many cases, the women had seen the doctor before 20 weeks of pregnancy, yet there was no action taken against these doctors for delaying the abortion until it was refused.

Moving forward

India is a signatory to CEDAW, as well as to the International Covenant on Economic, Social and Cultural Rights (ICESCR), and is therefore obligated to fulfill its obligations under these instruments, including CEDAW's General Recommendation 35.

Our experience, as documented in this paper, shows that medical professionals' education and training needs to include understanding of the concept of reproductive rights and the agency of those who have been raped to know what is best for them, particularly in regard to ameliorating the consequences of rape and sexual abuse. Forced pregnancy and motherhood should be considered a form of cruel and degrading treatment, and rejected.

In India, the medical profession has failed to keep up with the scientific and medical evidence and practice of carrying out an abortion safely at gestational stages beyond 20 weeks. This has in turn limited Indian women's and girls' access to abortion services and led to a denial of those services. There is an urgent need to teach these procedures to clinicians in India, and to equip medical practitioners to keep up with international knowledge and standards as prescribed by WHO and other experts.

The reality on the ground shows that pregnancy due to rape is not being addressed in India as either a physical or psychological health concern. Doctors turn women and girls away on flimsy grounds, even if they come before the 20-week limit, and distance themselves from providing the required care if the pregnancy is beyond 20 weeks, advising the families to go to court. There is no doubt that the reported cases are just the tip of the iceberg. Many more pleas may not even reach the courts due to social and economic barriers, and women and girls may be compelled to continue unwanted pregnancies in silence. There is an urgent need to create awareness among health professionals and judges that the rape law makes it mandatory for doctors to provide abortion without any delay for rape survivors. At the same time, doctors need to recognize that marital rape is a form of violence under The Protection of Women from Domestic Violence Act 2005, and that they have a legal duty to provide immediate treatment. Further, the law should require abortion to be provided without delay or excuse in instances of marital rape, as with all other cases of rape. Simultaneously, the criminal law should be amended to include marital rape as a form of rape, so that women may seek criminal action against their perpetrators if they wish to do so.

CEDAW's General Recommendation 35 on gender-based violence recommends establishing state accountability in the case of failure of ser-

vices to rape survivors. India has human rights responsibilities for women's health, and must be held accountable in the periodic reports that India is obliged to submit to the CEDAW committee. The issue of denial of abortion to rape survivors needs to be raised when India is due to make a periodic report to CEDAW, through shadow report for example, and during the Universal Periodic Reviews, as well in as reports to the UN Special Rapporteur on the right to health.

In addition to its international obligations, India's national obligation with regard to rape-related pregnancies is also clear. National guidelines issued to medical providers on provision of medico-legal care specifically state that abortion services are required for rape survivors. Failure to treat rape survivors in India is a punishable offense under Indian Penal Code 166, B. Punishment is accompanied by a fine and/or imprisonment up to one year. But since the passage of this law, not a single medical professional has been penalized when they have failed a patient. While immediate treatment does mention treatment of unwanted pregnancy, the doctors are still constrained by the MTP Act, which does not mention any penalty or punishment for denying an abortion to a woman or girl. There is only one Supreme Court judgment out of the many thousands that exist, in which the Bihar state government was asked to pay compensation to a woman who was not provided an abortion in time.[22] But the doctors went unpenalized.

Professional accountability of healthcare providers could be improved by developing guidelines and a checklist of good practice for gender-sensitive treatment for rape survivors. This could potentially reduce the barriers to reproductive health services, counseling, and abortion care for rape survivors. Such checklists and standards of practice have proven useful in reducing morbidity and mortality in surgery. Additionally, integrating a gender perspective in undergraduate medical education has proven effective in addressing provider prejudices and attitudes towards abortion and changing clinical practice.[23]

Lastly, the Federation of Obstetricians and Gynaecological Societies India (FOGSI) and the Indian Medical Association urgently need to share current information about safe abortions beyond 20 weeks of pregnancy, and achieving safety in later abortions. They also need to sensitize doctors to the negative social consequences of having to continue an unwanted pregnancy following rape, especially in children, and to train clinicians in WHO-recommended methods for providing abortion care without delay. FOGSI needs to take cognizance of developments in the medical field internationally, and the legal mandate to issue ethical guidance on the treatment of rape survivors. We recommend that this be developed and adapted in line with FIGO guidelines and used widely in training.

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References

1. Ministry of Law and Justice, *Protection of Children from Sexual Offences (POCSO) Act, 2012* (India: 2012). Available at https://www.ncpcr.gov.in/showfile.php?lang=1&level=1&&sublinkid=1288&lid=1513; Ministry of Law and Justice, *The Criminal Law (Amendment) Act, 2013* (India: 2013). Available at https://www.mha.gov.in/sites/default/files/CSdivTheCriminalLawAct_14082018_0.pdf; Ministry of Women and Child Development, The Protection of Women from Domestic Violence Act (PWDVA), 2005 (India: 2005). Available at https://wcd.nic.in/policies/protection-women-domestic-violence-act-2005-english.

2. Ibid.

3. Ministry of Health and Family Welfare. *Guidelines & protocols: Medico-legal care for survivors/ victims of sexual violence*. (India: 2014). Available at https://www.mohfw.gov.in/sites/default/files/953522324.pdf.

4. S. Arora, P. B-Deosthali, and S. Rege, *Responding to domestic violence in pregnancy* (Mumbai/India: Centre for Enquiry into Health and Allied Themes, 2018). Available at http://www.cehat.org/uploads/files/Responding%20to%20Domestic%20Violence%20in%20Pregnancy.pdf.

5. Centre for Enquiry into Health and Allied Themes, *Understanding dynamics of sexual violence: Study of case records* (Mumbai/India: Centre for Enquiry into Health and Allied Themes, 2018). Available at http://www.cehat.org/uploads/files/Understanding%20Dynamics%20of%20Sexual%20Violence%20Study%20of%20Case%20Records.pdf.

6. P. Bhate-Deosthali and S. Rege, "Rape survivors' right to abortion: Are doctors listening?" *The Wire*. Available at https://www.thewire.in/health/rape-survivors-right-to-abortion.

7. Ministry of Health and Family Welfare. *National Health Mission, Handbook on Medical Methods of Abortion to Expand Access to New technologies for Safe Abortion*. (India: 2016). Available at http://www.nrhmtn.gov.in/modules/MMA_Handbook.pdf.

8. "Indian Women's Health Charter" (presentation at 10th International Women and Health Meeting, New Delhi, India, 2007). Available at http://www.phmindia.org/wp-content/uploads/2015/09/Indian_Womens_Health_Charter.pdf.

9. Partners for Law in Development, "Country Assessment on Human Rights in the Context of Sexual Health and Reproductive Health Rights," *SSRN Electronic Journal* (2018), pp.103. Available at http://www.nhrc.nic.in/sites/default/files/sexual_health_reproductive_health_rights_SAMA_PLD_2018_01012019.pdf.

10. World Health Organization, *Safe Abortion: Technical and Policy Guidance for Health Systems* (Geneva: WHO, 2012). Available at https://www.apps.who.int/iris/bitstream/handle/10665/70914/9789241548434_eng.pdf?sequence=1; Ministry of Health and Family Welfare, *Comprehensive Abortion Care Training and Service Delivery Guidelines* (India: 2010). Available at http://www.nrhmhp.gov.in/content/guidelinescac.

11. M. Ellsberg, H. A. Jansen, L. Heise, et al., "Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: an observational study," *The Lancet* 371/9619 (2008); S. M. Lee-Rife, "Women's empowerment and reproductive experiences over the lifecourse," *Social Science & Medicine* 71/3 (2010).

12. A. Barua, H. Apte, and S. Dalvi, "Abortion in India," *Economic and Political Weekly* (2015), pp. 7–8.

13. T. K. S. Ravindran and P. Balasubramanian, "Yes" to Abortion but "No" to Sexual Rights: The Paradoxical Reality of Married Women in Rural Tamil Nadu, India, *eweb:272660*, 2004. Available at https://www.repository.library.georgetown.edu/handle/10822/990753.

14. M. Stillman, J. J. Frost, S. Singh, et al., *Abortion in India: A literature review*, p. 22. (New York: Guttmacher Institute, 2014).

15. The Wire (see note 6).

16. International Campaign for Women's Right to Safe Abortion, *Sexual abuse of girls followed by refusal of abortion: Adding insult to injury*. Available at http://www.safeabortionwomensright.org/india-sexual-abuse-of-girls-followed-by-refusal-of-abortion/.

17. A. Rastogi, (Presentation at National Dissemination Meeting on Safe Abortion Study, CommonHealth, Mumbai, India, March 2019).

18. Department of Health and Family Welfare, D.O.No. M.12015/58/2017-MCH (2017).

19. CEHAT, "MTP Act- Concerns with implementation on the ground by CEHAT" (presentation at Strategic planning workshop for building partnership for maternal health rights organised by CommonHealth, FIAMCO Bio-medical Ethics Center, St. Pius College, Mumbai, India, December 2-3, 2016).

20. L. Harris, D. Rossman, S. Sella, Letter to the Supreme Court of India, Statement on third trimester abortion from three US doctors (2017).

21. A. Rastogi (See note 17).

22. LatestLaws.com, Supreme Court directs Bihar Govt. to pay 10 Lakh compensation to Rape Victim Whose Right to Abortion was denied. Available at http://www.latestlaws.com/latest-news/supreme-court-directs-bihar-govt-pay-10-lakh-compensation-rape-victim-whos-right-abortion-denied/.

23. S. Rege, P. Deosthali, P. Shingare et al., "Integrating gender perspectives in gynecology and obstetrics: Engaging medical colleges in Maharashtra, India." *International Journal of Gynecology and Obstetrics* 146 (2019), pp. 132-138. Available at https://obgyn.onlinelibrary.wiley.com/doi/full/10.1002/ijgo.12834.

EDITORIAL

Human Rights for Health across the United Nations

BENJAMIN MASON MEIER AND LAWRENCE O. GOSTIN

Introduction

The United Nations (UN) plays a central role in realizing human rights to advance global health. Looking beyond state obligations, the UN has called on all its specialized agencies to implement human rights across all their activities. With globalization compelling these UN institutions to meet an expanding set of global challenges to underlying determinants of health, human rights are guiding these international organizations in addressing public health. These international organizations within the UN system are actively engaged in implementing health-related human rights—in both their mission and their actions to carry out that mission. Through this mainstreaming of human rights, global health institutions have embraced human rights treaty obligations as a framework for global governance. Given the dramatic development of human rights law through the UN and the parallel proliferation of UN institutions devoted to global health and development, there arises an imperative to understand the implementation of human rights in global health governance. This special section analyzes the evolving focus on health and human rights in global governance, examining an expansive set of UN institutions that employ human rights in responding to public health challenges in a rapidly globalizing world.

To understand the ways in which human rights are implemented, this special section examines the role of institutions across the UN system in the realization of human rights for public health. Drawing from our recent Oxford University Press volume on *Human Rights in Global Health: Rights-Based Governance for a Globalizing World*, this special section brings together several of the contributors to analyze ongoing efforts to reform UN institutions to mainstream human rights. These contributors—from academia, nongovernmental organizations, and the UN system—explore (1) the foundations of human rights as a framework for global governance, (2) the work of UN organizations across a range of health-related human rights, (3) the influence of rights-based economic governance on public health, and (4) the advancement of health through UN human rights institutions. Looking beyond the chapters in *Human Rights in Global Health*, this special section examines how international institutions are changing to meet the Sustainable Development Goals (SDGs), with sweeping implications for the mainstreaming of human rights for health across the UN.

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Human rights in global health governance

Institutions of global governance matter for the advancement of human rights in global health. In codifying a normative foundation for global governance in the aftermath of World War II, states came together under the auspices of the UN to develop human rights under international law.[1] Human rights law, establishing international norms to ensure global health with justice, has evolved to become a universally accepted framework, and the past 70 years have witnessed the expansive development of international human rights law to define the highest attainable standard of health.[2] Conceptualizing health injustices as rights violations, these health-related human rights offer universal standards to frame government responsibilities for the progressive realization of health and facilitate legal accountability for rights-based health policy.[3] As globalizing forces have pressed international organizations to meet changing global health challenges, human rights have come to guide these institutions of global health governance.[4]

To ensure that lawyers are prepared for the future challenges of human rights in global health governance, Thérèse Murphy's contribution to this special section, "Health and Human Rights' Past: Patinating Law's Contribution," seeks to elucidate the history of health and human rights. Murphy argues that the history of the health and human rights movement has thus far been "monochrome"—focusing primarily on a few specific events (such as the HIV/AIDS pandemic in 1990s), instruments (such as General Comment 14), judgments (such as access-to-medicines cases from South Africa, India, Brazil, Colombia, and Venezuela), UN organizations (such as the World Health Organization), and specific individuals. Looking beyond these traditional histories, Murphy suggests that a complete understanding of the field requires an understanding of other histories, including regional human rights systems and regional offices of UN organizations. Her article proposes that crucial gaps in the history of the field should be filled by focusing on (1) health and human rights law "favorites," including the right to health and human rights-based approaches to health, and (2) "neglected areas," including the right to science and the relationship between international human rights law and ethics.

As human rights law has evolved to become foundational to global health governance, the expansion of global governance institutions has warranted a wider sharing of human rights responsibilities for health across the UN. These international organizations are seen not only as instrumental to the development of international human rights law but also as essential to assuring the implementation of human rights obligations in a rapidly globalizing world.[5] The UN has sought to formalize these human rights implementation responsibilities across the entire global governance system, with the interconnected nature of the SDGs facilitating the coordination of these multisectoral actors, catalyzing rights-based partnerships across the UN's health-related organizations.[6] Translating international law into global governance, UN organizations seek to mainstream human rights across their policies, programs, and practices.

UN organizations mainstream health-related human rights

Following the end of the Cold War, the 1993 World Conference on Human Rights declared a new global consensus on human rights, calling for increased coordination on human rights across the UN. The resulting Vienna Declaration and Programme of Action established "the foundation for a holistic and integrated approach to human rights not only by the human rights machinery but also by the entire United Nations system."[7] Given the Vienna Declaration's post-Cold War consensus on the centrality of human rights in global governance, the UN Secretary-General called for the enhancement of human rights as a "cross-cutting" approach to all of the UN's principal activities and programs, seeking to "mainstream" human rights into the full range of UN activities.[8] Various international organizations took up this call to mainstream human rights, and this special section explores how health-related human rights have been integrated across the UN, beginning with the World Health

Organization (WHO) and expanding to encompass a larger set of international organizations that address health determinants. Contributing authors to this special section analyze WHO's contemporary efforts to reassert health-related human rights for vulnerable populations to support universal health coverage (UHC). As a basis for securing UHC, human rights are seen as a way of advancing a more equity-oriented approach to health, centered on reaching the most marginalized under the SDGs.[9]

UHC has become a unifying rights-based platform in global health governance. With UHC articulated in global health policy through a number of UN General Assembly and World Health Assembly resolutions, these resolutions increasingly reference human rights—specifically the right to health—as an overarching framework for achieving UHC goals. Despite this high visibility of UHC, Helena Nygren-Krug contends in her article, "The Right(s) Road to UHC," that the potential for UHC is limited "by its own ambiguity": the scope and content of UHC is not consistent, and it remains unclear how UHC and human rights relate to each other. Concluding that UHC is a human rights imperative that requires national laws, policies, and practices to align with human rights norms and principles, Nygren-Krug addresses five areas that require specific attention to ensure that a human-rights based approach is used to help countries achieve UHC.

In bringing human rights specificity to UHC, Flavia Bustreo and Curtis Doebbler have developed a commentary, "Universal Health Coverage: Are We Losing Our Way on Women's and Children's Health?," to highlight the specific failure of UHC to prioritize women's and children's health, moving UHC further away from achieving health for all. While UHC goals are commendable, Bustreo and Doebbler argue that it is unclear whether these goals are an accurate expression of the right to health given the apparent failure to meet commitments to women's and children's health. Where WHO has expressed its continuing investment in implementing the right to health, as evidenced by the WHO-OHCHR Framework of Cooperation, Bustreo and Doebbler argue that this type of rights-based partnership could be an important step for prioritizing women and children in UHC strategies.

Despite these WHO initiatives to advance the human right to health, there is a need to look beyond WHO to address multisectoral efforts to implement human rights for public health across the entire UN system. Where WHO continues to face obstacles to implementing human rights for health, it will be necessary to look to collaboration across international organizations to foster global solidarity and bolster institutional efforts to mainstream human rights in addressing underlying determinants of health.

Funding agencies incorporate human rights in international health assistance

In an expanding global health landscape limited by scarce resources and increased competition among a growing number of stakeholders, funding agencies can provide crucial international support for the realization of health-related human rights. Human rights mainstreaming is often presented in the context of "development cooperation." Multilateral economic governance agencies have sought to implement a rights-based approach to development cooperation for health, breaking the vicious cycle linking economic poverty with morbidity and mortality. Increasingly relevant in global health governance, these institutions have been driven either (1) to address public health as a means to economic development or (2) to address economic development as a means to realize health.[10] With the latter approach aligned with a rights-based approach to health, this special section highlights the role of human rights in economic governance and international funding for global health. Contributing authors explore how the international structures of economic governance, through financial support for global health, have influenced the realization of health-related human rights.

Shifting from the MDG to the SDG era, Rachel Hammonds and colleagues focus on how UHC financing should be delivered, examining whether ongoing efforts to achieve UHC are in line with the realization of the right to health and

the right to health care. Their article, "UHC2030's Contributions to Global Health Governance that Advance the Right to Health Care," contends that it is necessary to examine how key global governance institutions such as WHO and the World Bank interact with civil society. In examining the influence of the International Health Partnership for Universal Health Coverage 2030 (UHC2030)—a multi-stakeholder partnership focused on coordinating and amplifying efforts by WHO, the World Bank, governments, civil society organizations, and the private sector—Hammonds and colleagues analyze how human rights have been neglected in the journey toward UHC. Offering a preliminary assessment of UHC2030's contribution to global health governance and national health participation, they find that there has been little attention to shared responsibility for advancing the right to health in UHC definitions and programming, concluding that the right to health must be acknowledged in policy documents and that domestic and international financing must be increased.

The Global Fund to Fight AIDS, Tuberculosis, and Malaria has explicitly sought to integrate human rights principles into its institutional funding practices, and Ralf Jürgens and Diederik Lohman, as part of our human rights across the UN project, conducted a review of Global Fund policies and policymaking processes to determine whether they reflect human rights considerations. Their resulting article, "Integrating Human Rights Considerations in All Policies and Policymaking Processes: Realizing Another Objective of the Strategy of the Global Fund to Fight AIDS, TB and Malaria" (forthcoming, but not included in this special section), finds that while the Global Fund has made progress in its rights-based practices, this funding agency has not yet reached its potential for advancing human rights priorities. Concluding that the Global Fund must take further steps to fulfill its human rights objectives, Jürgens and Lohman recommend scaling up programs to reduce human-rights related barriers, strengthening protections to guard against negative human rights impacts, and requiring internal standards to mandate human rights considerations in policymaking processes.

Through international public health financing, multilateral funding partnerships for health can either enhance economic governance to realize health-related human rights or advance economic ends in ways that damage public health. While these international organizations do not universally view human rights as part of their institutional mission, they continue to have a disproportionate influence on the ways in which policy makers raise and spend resources on health, and as a consequence of their influence, these international funding institutions will remain central to mainstreaming human rights in global health, especially where they have embraced human rights in their funding processes.

Human rights agencies advance the right to health

Where human rights have been instrumental in global health governance, health-related human rights are also advanced where health considerations are incorporated into human rights governance. The UN human rights system has an essential role in assuring the implementation of human rights, collaborating with global health institutions to "welcome, encourage, foster, support and scrutinize" human rights mainstreaming efforts.[11] This special section identifies ways in which institutions that are part of the UN human rights system have proven crucial to advancing the human right to health, with contributing authors examining how health has increasingly become relevant to human rights efforts across the UN.

Gillian MacNaughton and Mariah McGill examine "The Challenge of Interdisciplinarity in Operationalizing the Right to Health," analyzing the interorganizational collaborations of the Office of the UN High Commissioner for Human Rights (OHCHR). As the UN agency charged with mainstreaming human rights across the UN system, MacNaughton and McGill recognize that the OHCHR "faces considerable challenges in moving beyond legal conceptualization to operationalization of the right to health in practice." Based on

interviews across the UN, they conclude that the full operationalization of the right to health will require the OHCHR to move toward a greater interdisciplinary approach to human rights, necessitating that it include health professionals in mainstreaming efforts; promote understanding of the right to health as a broad right that includes social determinants of health; enable and support the development of deep expertise on the right to health; and enhance appreciation for the right to health across all UN agencies.

Yet, human rights efforts would mean little without mechanisms to ensure accountability for their implementation. Established in 2006 and overseen by the UN Human Rights Council, the Universal Periodic Review (UPR) provides a critical new accountability mechanism in the UN's global human rights architecture. Judith Bueno de Mesquita's article, "The Universal Periodic Review: A Valuable New Procedure for the Right to Health?," presents an analysis of the right to health in UPR processes, examining the prominence of health in UPR recommendations, the types of health issues covered, and the actions required by states. With UN member states undergoing assessments every five years, UPR recommendations facilitate state accountability for improving compliance with human rights obligations. While finding that the right to health appears increasingly in UPR recommendations, Bueno de Mesquita concludes that the quality and specificity of the recommendations remains insufficient, advocating greater engagement by health stakeholders with UPR processes to ensure that health-related recommendations provide specific guidance for states seeking to realize the right to health.

Beyond its support for mainstreaming human rights in global health governance, the UN human rights system is mainstreaming public health in human rights governance, with human rights institutions independently implementing human rights for global health and assuring accountability for state efforts to realize the highest attainable standard of health.[12]

Expanding efforts to mainstream human rights for health across the UN

Human rights norms and principles increasingly provide legitimacy to institutions of global governance, as this special section demonstrates, yet there remains no consistent, universal approach to human rights mainstreaming for public health across the UN. As a consequence, international organizations have demonstrated varied approaches to human rights implementation through their institutional structures. These decentralized institutions of global governance have mainstreamed human rights in their organizational policies, programs, and practices; however, the fragmentation of these uncoordinated human rights initiatives raises a comparative research imperative to assess the institutional structures that are conducive to human rights implementation. This imperative for comparative analysis is taken up in *Human Rights in Global Health*, which systematically examines the role of global institutions in operationalizing human rights for global health.[13]

These institutions matter for the advancement of health-related human rights across the UN. Drawing from *Human Rights in Global Health*, the scholarship highlighted in this special section identifies the evolving rights-based actions of global institutions and analyzes the facilitating and inhibiting factors for human rights mainstreaming in global governance for health. Where international organizations across the UN continue to face challenges to mainstreaming human rights, it becomes clear from this comparative analysis that the development of multisectoral partnerships, coordination of rights-based approaches, and collaborations across institutions and stakeholders can facilitate the implementation of health-related human rights. As these global governance actors push ahead to meet the SDGs, it is necessary to look across the UN to examine the continuing role played by international organizations in operationalizing human rights for global health.[14]

Such comparative institutional analyses can assure that human rights mainstreaming in global governance can realize human rights in global

health. While this special section does not present a comprehensive overview of the myriad of stakeholders that have a role in an expanding global health governance landscape, this initial scholarship recognizes how each institution is engaging human rights in unique ways and through distinct structures. The contributions to this special section emphasize the paths through which an expanding number of international organizations—despite challenges—are actively seeking to address interconnected health-related human rights in ways that reflect interrelated determinants of health. As these organizations are only just beginning to develop institutional structures to mainstream human rights in their policies, programs, and practices, it will be necessary to continue to look across the UN to understand evolving multisectoral efforts to translate human rights into global governance—identifying good practices for human rights implementation as a foundation to advance global health with justice.

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References

1. P. Alston, "Conjuring up new human rights: A proposal for quality control," *American Journal of International Law* 78/3 (1984), pp. 607–621.

2. L. O. Gostin, B. M. Meier, R. Thomas, et al., "70 years of human rights in global health: Drawing on a contentious past to secure a hopeful future," *Lancet* 392/10165 (2018), pp. 2731–2735.

3. S. Gruskin, S. Ahmed, D. Bogecho, et al., "Human rights in health systems frameworks: What is there, what is missing and why does it matter?" *Global Public Health* 7 (2012), pp. 337–351.

4. B. M. Meier and L. O. Gostin, "Introduction: Responding to the public health harms of a globalizing world through human rights in global governance," in B. M. Meier and L. O. Gostin (eds), *Human rights in global health: Rights-based governance for a globalizing world* (New York: Oxford University Press, 2018).

5. P. Hunt, "Configuring the UN human rights system in the 'era of implementation': Mainland and archipelago," *Human Rights Quarterly* 39/3 (2017), pp. 489–538.

6. B. M. Meier, M. M. Cinà, and L. O. Gostin, "Advancing human rights through global health governance," in B. Mason Meier and L. O. Gostin (eds), *Foundations of global health and human rights* (New York: Oxford University Press, forthcoming).

7. M. Robinson, Five-Year Review of the Implementation of the Vienna Declaration and Programme of Action: Interim Report of the United Nations High Commissioner for Human Rights, UN Doc. E/CN.4/1998/104 (1998), para. 23.

8. UN General Assembly, G.A. Res. 51/950, UN Doc. A/51/950 (1997).

9. C. Williams and P. Hunt, "Neglecting human rights: Accountability, data and Sustainable Development Goal 3," *International Journal of Human Rights* 21/8 (2017), pp. 1114–1143.

10. B. M. Meier and A. M. Fox, "Development as health: Employing the collective right to development to achieve the goals of the individual right to health," *Human Rights Quarterly* 30 (2008), pp. 259–355.

11. Hunt (see note 5).

12. W. O'Neill and V. Bye, *From high principles to operational practice: Strengthening O.H.C.H.R. capacity to support U.N. country teams to integrate human rights in development programming* (Geneva: Consultancy report to the Office of the High Commissioner for Human Rights OHCHR, 2002).

13. United Nations Development Group, *The human rights based approach to development cooperation: Towards a Common Understanding Among UN Agencies* (2003). Available at https://undg.org/document/the-human-rights-based-approach-to- development-cooperation-towards-a-common-understanding-among-un-agencies.

14. B. M. Meier and L. O. Gostin, (eds), *Human rights in global health: Rights-based governance for a globalizing world* (New York: Oxford University Press, 2018).

Health and Human Rights' Past: Patinating Law's Contribution

THÉRÈSE MURPHY

Abstract

This article argues that to be able to look forward, lawyers within the health and human rights movement need to do more looking back. It is prompted by a simple question: do we have a history of health and human rights law and lawyering? Finding nothing that qualifies, the article asks how we might fill that gap. Focusing on international human rights law, it prescribes histories of health and human rights law "favorites," notably the international human right to health and human rights-based approaches to health. It also prescribes histories of neglect: histories exploring the low levels of attention to certain issues, such as the right to science, that seem directly relevant to health and human rights. The article emphasizes that neither of these history projects should be a search for origins or an opportunity to pitch linear "onwards and upwards" accounts of health and human rights law. The prescription is for histories that are open to the ebb and flow of particular international human rights law norms and approaches as they have come into being and crisscrossed the United Nations and beyond.

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Introduction

Some say that this is the age of human rights; others insist that the age of rights is over, disappearing, or stalled at least for now. Taking a critical but enabling stance on the matter is hard, and in international human rights law circles in particular, the mood is downbeat. Little has been going well, and the field feels assailed on all fronts. Its credentials have been hit hard amid a pullback from internationalism and international institutions.[1] Conceived as "palaces of hope," international institutions are now less likely to be held up as rational and efficient, and more likely to be seen as remote from those who need protection, weak when faced with power, unduly focused on funding, and mired in round after round of reform.[2] At the same time, populist-authoritarian governments are on the rise; so, too, are understandings of sovereignty that foreground non-interference and state-led development. Further, all parts of the world have seen moves against both human rights and environmental defenders.[3] Internationally, governments of various political colors continue to make attempts to deplete human rights standards. Human rights proponents, too, have issued calls for restraint, raising concerns that the proliferation of new rights and, more broadly, the tendency to frame so many problems in human rights terms create an overload that damages the credibility of rights.[4]

There is also a volubility to longstanding criticisms of international human rights law. These criticisms ridicule norms that are said to be imprecise and ambiguous and subject to allegedly laughable standards such as "progressive realization." They also point to a chronically unconvincing enforcement architecture and to routine violations, which are cited as evidence of the general ineffectiveness and lack of impact of this legal field.[5] Recently, a spate of critical histories of human rights has deepened international human rights law's problems.[6] Relatedly, across the world, tough questions have been raised by the persistence of "geographies of injustice" and by the growing gap everywhere between the rich and the rest.[7] One question in particular has been hitting home: has the human rights movement settled for sufficiency (that is, for "just enough" or a "minimum core"), sloping away from questions of political economy—above all, how to address economic inequality, including the ways in which it intersects with other inequality drivers such as gender, disability, and sexual orientation?[8]

This is my departure point. In this article, I ask, is health and human rights law and lawyering adequate to this present and prepared for the future? Focusing on international human rights law, I suggest that we are competent in many ways, but there is one way in which we are not: we have no history of health and human rights law and lawyering. And so, insisting that we "read the future by the past," I ask how this gap might be filled.[9] There are a number of options. For instance, we should read, learn from, and respond to more work by historians on aspects of the broader health and human rights movement: historians including Sunil Amrith, Alison Bashford, and Eileen Boris and Jennifer Klein.[10] And we should learn about historical methodology, from what it means to write genealogically, to the pros and cons of microhistories.[11] Here, however, I focus on a third option: areas we could foreground in our history writing. I nominate two. The first is histories of health and human rights law "favorites," such as the right to health and, more broadly, human rights-based approaches to health. And the second is histories of neglect or omission, in particular the right to science, and relatedly how international human rights law relates to technology and how ethics, as a regulatory tool widely advocated in the field of science and technology, relates to international human rights law.

I say something about mindset too. The histories prescribed here have to be genealogical. This means they will not obsess about origins, breakthroughs, or linear development, and they will not lapse into "happy ever after" or "doom and gloom." Instead, they will attend simultaneously to continuity and change over time. Equally, they will not leap from one aspect of international human rights law to the next, from one instrument, judgment, or treaty body communication to the next. That would make us incurious about how particular laws have been generated, bolstered, stripped back,

or, more broadly, co-produced by social practices and popular understandings.[12] If we are to cultivate legal literacy, a different approach will be needed, one that is open to experience—to the emergence, deflection, distortion, and even destruction of particular human rights law norms and approaches as they have traveled across the United Nations (UN) and beyond and have been transformed in the process and perhaps been transformative too.

Doing things differently?

I want to begin by challenging the mood of the moment as regards international human rights law. For lawyers like me whose work relates to health and human rights, international human rights law feels far from a dead end. We show no signs of disengagement either from law in general or from international human rights law in particular. Moreover, economic, social, and cultural rights, still widely neglected in many other human rights law circles, continue to be center stage for us. There is, for example, palpable interest in generative concepts associated with the right to health—from availability, accessibility, acceptability, and quality (collectively known as AAAQ), to maximum available resources, progressive realization, and international assistance and cooperation. Interest continues to cascade toward other human rights too, which is welcome because it eases the pressure created by the embrace of the underlying determinants of health within the right to health.[13] It also builds appreciation of the independent role of other human rights in achieving the aims of the health and human rights movement. A further welcome feature is the span of health and human rights lawyers' engagement: stretching across "crisis" and "the everyday," it encompasses not just pandemic prevention and preparedness but also the quotidian violations produced, for example, by user fees in health care or lack of respect for dignity in childbirth.

Health and human rights lawyers' multi-institutional approach stands out too. True, there were lean years when commentary on access-to-medicines litigation felt too dominant (albeit the backdrop was one of extreme doubt as to whether judges would hear cases concerning economic, social, and cultural rights). Yet, even then, there was little sense of health rights litigation as a single phenomenon, in part because commentators generally ranged beyond exemplars (namely, courts in South Africa and India), and in part too because commentators looked at both international and national courts, including how they were interacting. Relatedly, commentators examined more than the judiciary, extending their range to include both civil society's engagement with law and the ways in which domestic judicial attitudes were affected by the nature and quality of local political leadership.

Overall, however, in the lean years, there was a sense of commentators having to be either "for" or "against" the judicialization of health. Fortunately, engagement with right-to-health litigation is now moving beyond this narrow approach. Today's engagements tend to be *in concreto*.[14] By this I mean that they draw out procedural issues and particular styles of judicial reasoning, including how different courts use (or do not use) international human rights law to navigate the minefield of judicial competency and legitimacy that surrounds health litigation. Today's engagements also draw out the ways in which litigation can be about more than access to medicines and individual demands. And they look "beyond judgment"—that is, beyond the text of judicial decisions toward compliance and even structural changes. Further, these explorations are now more likely to draw on a seam of non-legal perspectives and field experiences, which helps expand knowledge about right-to-health litigation and offers new ways of capturing, conceiving of, and responding to its heterogeneous nature.

To be fair, even in the lean years, health and human rights lawyers did range beyond courtroom walls. All branches of government were of interest; so too were a wide range of international institutions, not just the World Health Organization (WHO) and the human rights treaty bodies at the United Nations.[15] In addition, a focus on practical implementation led to interest in clinics, hospitals, prisons, and the like, while a focus on everyday accountability brought ombuds, regulators, and others into the picture. As a consequence, health

and human rights lawyers have knowledge, and more broadly a sensibility, that is sometimes missing in other human rights law circles—a sensibility that spans rights mobilization, planning, budgeting, programming, and monitoring, evaluation, and accountability.

Relatedly, when health and human rights lawyers speak about the past, sequences of law—the act of leaping from one law to the next—generally do not squeeze out everything else. There is no sense of a search for a starting point when health and human rights law began, or for a breakthrough or rupture indicating when it came to matter more than it had in the past. Similarly, although UN instruments, treaty bodies, and the like are well represented when we speak about health and human rights law, there is no sense of them as the only makers of health and human rights law history. People, nongovernmental organizations, events, objects, and more are present too.[16] More importantly, health and human rights lawyers have largely avoided human rights isolationism. By this, I mean four things: first, health and human rights lawyers typically place international human rights law within human rights law more broadly, including domestic and regional human rights law. They do not cleave to a separate-spheres model: instead, they recognize that different human rights legal orders work together (albeit in messy, sometimes conflictual, and always reversible ways) in order to promote and secure respect for human rights. They also recognize that as human rights law travels, it tends to be transformed, taking on different roles, and potentially different meanings, in individual states and international organizations.[17] This means that Geneva—international human rights law's "home town"—isn't always at the center: its human rights institutions are important, but mainly as leverage for work with other international actors and as places to develop links, tactics, and social capital, which can be put into play at the local level.

Second, health and human rights lawyers locate international human rights law within a broader international legal frame—as, for instance, when the drive for access to antiretrovirals targeted not just international human rights organizations but trade ones too. Third, although international human rights law has been widely invoked by health and human rights lawyers, we do not define ourselves through that idiom. We practice a kind of critical faith in the possibilities of law in general and international human rights law in particular. So, for example, we are committed to describing and developing the "legal determinants of health."[18] At the same time, however, we are averse to anything that smacks of law out-of-context. Similarly, we see the power—positive and negative—of law and legal institutions, but generally speaking we also see that power takes many other shapes and forms. And, at our best, we see that law's power can both complement and rub against other forms of power (including, for example, within a health clinic, a setting where non-legal rules and conventions are also in play) and is riven by endless internal tensions.[19]

Health and human rights lawyers' practice-oriented approach—which is our fourth key characteristic—helps enable this. In international human rights law circles more generally, a practice orientation tends to be contrasted with orientations that are philosophical or political. Typically, it signals an interest in looking at what courts do with rights. For health and human rights lawyers, being practice oriented means something different: it means an ethical commitment to give voice to human suffering and to ameliorate it.[20] If international human rights law serves that purpose—and there is evidence to indicate it can do so—then health and human rights lawyers take advantage of this field of law. But if other idioms or circuits seem relevant, we do not turn our back. So, for example, we engage with synonyms for human rights, including universal health coverage as a "practical expression of the concern for … the right to health."[21] This is a gamble fraught with tension, which is manageable only when strategy, tactics, and methods are considered in situated and concrete ways.

Is something missing?

So, there is much to praise in the practice of health and human rights law. At the same time, I sense that something is missing. Why is there no history

of health and human rights law and lawyering? And isn't it curious that this history is missing when elsewhere, for at least a decade, many have been working out (and sometimes griping about) what histories of human rights, and international law more generally, might be or might become?

It is not that we never write about our history. The problem is that what we write is monochrome. By and large, we foreground just one story when we recount health and human rights law past. This story places the role of human rights law in responding to the HIV/AIDS pandemic at center stage. Key parts are given to the Universal Declaration of Human Rights, General Comment No. 14 from the UN Committee on Economic, Social and Cultural Rights, the increasing number of constitutions that include a guarantee of the right to health, and access-to-medicines judgments from courts in South Africa, India, Brazil, Colombia, and Venezuela. References to key people and organizations follow a similar pattern: UNAIDS, WHO, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Trade Organization, Jonathan Mann, the Treatment Action Campaign, and the like are repeat players. Our periodization also tends to be either "before and after" HIV/AIDS or during stages of the pandemic.

I would not want to exclude any of this; my concern is that its dominance downplays other significant parts of health and human rights law's history. Here are examples of what is left out: first, sexual and reproductive health and rights sometimes have no more than a walk-on role and are located almost exclusively in the context of either the HIV/AIDS pandemic or maternal health.[22] Second, distinctive characteristics of the right to health tend to be submerged by attention to the broader question of human rights-based approaches to health.[23] Third, regional human rights systems, including how these systems invoke international human rights norms and approaches, and whether and how their compliance records differ from their international and national counterparts, are little discussed. Fourth, regional offices of organizations such as UNICEF, the Pan American Health Organization, and WHO are little discussed. We have also neglected agencies such as the European Union's European Centre for Disease Prevention and Control and its African Union counterpart, the Africa Centres for Disease Control and Prevention, which was inaugurated in early 2017. And where organizations, agencies, and partnerships, at whatever level, are discussed, it tends to be as discrete bodies, without deep engagement as to how and why particular human rights law norms and approaches resonated or not in more than one department in any particular organization, or in more than one organization. As a result, we are short on understanding with respect to the messy, competitive context that surely operates within and across key health and human rights actors.

So, the nub of my argument is that our history writing needs to take on new colors—it needs to proliferate in ways that promote law's patina. If we can achieve this, it will create a range of positive outcomes. First, we will help ourselves by learning from the past for the future of health and human rights law. Reflexiveness requires history (preferably, histories that mobilize a genealogical methodology, committed to investigation rather than triumphal reconstruction and alert to the ways in which routine repetitions generate authority). Second, history will help us gauge whether we are dealing with "friend" or "foe" when proponents of global health law praise international human rights law, and the right to health in particular, but call for them to be resized within their new legal field in order to overcome what they see as the obvious deficiencies of human rights law.[24] Finally, histories of health and human rights law and lawyering will help the health and human rights movement, and the human rights movement more broadly, imagine less fraught futures than those conjured by the current, incessant crisis-talk. We know that history is one of the places where a politics of international human rights law is being played out today.[25] Relatedly, we know that history writing is a form of "world making," which intentionally or not, serves certain interests and does disservice to others. It is time for us, as health and human rights lawyers, to investigate our own "world making"—including the limited, almost single-story history we current-

ly have, as well as the histories we could have.

How to proceed? The remainder of this article prescribes two options: first, a history of health and human rights law "favorites," and second, a history of what we have neglected.

Histories of health and human rights law "favorites"

Getting the granularity right will be a challenge, which means it might help to start with what we "know"—namely, access to medicines. We could ask, how have human rights norms and approaches been deployed when claims concerning access to medicines traveled from forum to forum? Can we, for example, draw out how the social and historical density of particular global organizations caused claims to develop different resonances in different places? Put differently, what or who influenced what and whom, in what ways, and with what effects? And while this history of a health and human rights law "favorite" should look at WHO, UNAIDS, the World Trade Organization, and UN human rights treaty bodies, it should also look at the lesser-studied mechanisms—for example, the UN Special Procedures.[26]

These questions about the right to health in the access-to-medicines movement are motivated by the lively literature on the "vernacularization" of rights, which examines how rights travel and how, in so doing, they are transformed and translated, and potentially become transformative too.[27] My questions add to that literature by asking not just how norms and approaches associated with the right to health have traveled from the global to the local (or vice versa), but also about lateral travel from one international organization to another. Is there evidence, for example, that organizations that started with a rights-based approach (such as UNAIDS) have human rights "in their DNA"? And what has been the impact of individual leaders and of dedicated human rights departments within particular organizations? Further, in what ways have "crises," whether internal to the organization or external (for example, a pandemic), affected a formal commitment to rights? Regional organizations should be considered too. How have particular norms and approaches traveled "down" to these organizations from their international counterparts, traveled "up" from particular locals, or traveled across from one regional organization to another? A similar approach could be taken to the growing number of regional networks of cooperation in the health field. And, if possible, the role of management consultants, who have been used extensively by both international and regional organizations, should also be studied. As norms and approaches have traveled (or not) and been transformative (or not), these consultants have been the least visible "translators," and we urgently need to know more about their influence.[28]

There is also the question of when the right to health, or a rights-based approach more broadly, has been translated too far. At times, as noted earlier, health and human rights lawyers have valorized stealth; by this I mean that we have been committed to human rights, but we have also been willing to work with alternatives—from the Millennium Development Goals and development ideas and initiatives more broadly, to universal health coverage. Sometimes these alternatives have come to us packaged as the right to health "by another name," or as a "practical expression" thereof. Equally, sometimes it has been clear that the alternative is meant to avoid human rights in general or part thereof (say, for example, women's rights); and sometimes the claim has been that human rights are not being avoided, just included implicitly rather than mentioned explicitly.

This has been, and is, troublesome terrain, which we need to investigate further. On the one hand, health and human rights lawyers have not pitched rights as the only social justice frame, and being strategic does tend to require nonstandard, even unappealing, choices. On the other hand, synonyms for rights seem to have been used far more in relation to the right to health and other social rights than for civil and political rights. History might help us determine if their continued use will limit opportunities to disseminate, test, and refine norms and approaches associated with the right to

health. Further, as Paul Hunt has explained, where policy makers promote implicit engagement with the right to health or other social rights,

> *it means that only those in authority know whether and when the social right is being taken into account and, if it is, how it is interpreted and applied. Such arbitrariness is inconsistent with the essence of human rights and, indeed, the rule of law.*[29]

Of course, histories of our "stealth" practices will not be able to map this terrain in full, providing a certain guide as to the pros and cons of "rights by another name." But they might identify incontrovertible failures, creating conditions in which we could learn whether translations that go too far have particular markers.

We will also need questions designed to draw out how international and regional organizations have navigated against state resistance to the right to health. The popular view holds that governments—or at least the governments of the most powerful member states—direct these organizations. The advantage of this view is that it constrains naivety about the power of international and regional organizations; the disadvantage is that we may forget to look at how organizations find wiggle room. Here, for example, is Peter Piot explaining that when he was head of UNAIDS, he found "there was space to push the edges of policies that were not popular with many member states, such as gay rights and harm reduction among drug users, and even access to antiretroviral therapy when nearly all high-income countries were opposed to use of development resources for such treatment."[30]

One final set of questions offers another reason why we should commence our histories of health and human rights law "favorites" with a focus on the access-to-medicines movement. This movement has potential to tell us whether international human rights law in general, and health and human rights law in particular, have sloped away from economic inequality. Does the history of access to medicines suggest that one must be either for the market or for the state? Or does it leave space to imagine other options?[31]

Histories of neglect

Of course, some of our history gaps are bigger than others. I call these "omissions," although I recognize that views will differ on what counts as a major omission. I suggest that our guide should be neglect—specifically, what we have neglected regardless of how we date health and human rights law. My list prioritizes the following three omissions. The first is the right to science, which I would describe as widely neglected (although it is now the subject of a draft general comment by the Committee on Economic, Social and Cultural Rights).[32] The second is international law on the life sciences, which is neglected if we discount fleeting references to the UN Declaration on Human Cloning, the Council of Europe's Convention on Human Rights and Biomedicine, and a trilogy of instruments from UNESCO.[33] Lastly, the relationship between health and human rights law and technologies more broadly, including the rise of the "digital welfare state," is also underexplored.[34]

This neglect is surprising and frustrating. I say this, first, because "legal literacy"—by which I mean not more law but a willingness to explore law's capacities—seems essential in countering the popular view which holds that when it comes to new technologies, law either dawdles or moves too soon and, as a result, is best kept out of the picture.[35] And, second, because it has been proposed that big data could help fill statistical gaps, complementing conventional data sources, as the world reaches for Sustainable Development Goal 3, "health for all," which has 13 targets and 27 indicators. Health and human rights lawyers have reason to be skeptical here. Experience with indicators linked to the Millennium Development Goals tells us that numbers speak louder than words and that this can have distorting and damaging effects. Further, as Carmel Williams and Paul Hunt have pointed out, the digital divide between and within countries could become an even greater human rights risk if we turn to big data—data arising from online search queries, web posts, Twitter, and other social media—in the quest to fulfill both Sustainable Development Goal 3 and, more broadly, the call "to leave no one

behind."[36] In my view, it would be a great deal easier to harness health and human rights law instincts of this sort if we had histories that explored our own past engagements with technology.

A related omission also concerns me: what do we know regarding how health and human rights lawyers have conjured what falls outside law? Specifically, how have we shaped non-law through our engagements with both international human rights law and law more generally?[37] How, for example, have we shaped the relationship between international human rights law and ethics? Have we elided ethics and international human rights law, or have we opposed them, sequenced them, or set them apart in some other way? And what effects has this had on how we and others view the capacities of ethics and international human rights law, respectively? These questions are pressing for a range of reasons, not least the increased calls for an ethics of artificial intelligence—calls that rarely make reference to the merits of taking a rights-based approach to this technology.

I am not making a case for hubris among human rights lawyers. But I am suggesting that amid quotidian references to "law and ethics," there is room to reflect on how health and human rights lawyers construct what is within the realm and capacity of international human rights law, and conversely what is not.[38] Reflecting on this should also open up scrutiny of the present passion for an ethics of artificial intelligence (and other approaches such as data justice, data protection, and "responsible research and innovation"), including what might be lost if human rights law were to be sidelined as a governance mechanism and regulatory tool in this field, and what threats and challenges will need to be faced by human rights law if it is called on to engage in this terrain.

Conclusion

I accept that health-and-human-rights-law history writing will not be easy. But it is easy, I think, to understand why these histories are needed. In this article, I have argued that if the past speaks to the future of health and human rights law, and if it is a window into the wider world of international human rights law, we ought to be able to answer affirmatively when asked, "Is there a history of health and human rights law and lawyering?" I have also argued that we ought to begin our history writing by focusing on health and human rights law "favorites"—notably, the right to health and human rights-based approaches to health—but with a commitment that we will also look at what we have neglected, including both the right to science and the relationship between international human rights law and ethics. Of course, whatever the history, the challenge is to get the level of granularity right. And here the article has made one final suggestion: let us begin with what we know best—health and human rights law and lawyering in the access-to-medicines movement.

References

1. P. Alston, "The populist challenge to human rights," *Journal of Human Rights Practice* 9/1 (2017), pp. 1–15.
2. R. Niezen and M. Sapignoli (eds), *Palaces of hope: The anthropology of global organizations* (Cambridge: Cambridge University Press, 2017).
3. See, for example, Front Line Defenders, *Global analysis 2018*. Available at https://www.frontlinedefenders.org/en/resource-publication/global-analysis-2018.
4. See, for example, H. Hannum, *Rescuing human rights: A radically moderate approach* (New York: Cambridge University Press, 2019).
5. See, for example, E. A. Posner, *The twilight of human rights law* (New York: Oxford University Press, 2014).
6. See, for example, S. Moyn, *Not enough: Human rights in an unequal world* (Boston: Harvard University Press, 2018); S. Moyn, *The last utopia* (Boston: Harvard University Press, 2010).
7. See, for example, U. Baxi, "Operation Enduring Freedom: Toward a new international law and order?," in A. Anghie, B. Chimni, K. Mickelson, and O. Okafor (eds), *The third world and international order: Law, politics and globalization* (Leiden: Brill/Martinus Nijhoff, 2003), p. 46.
8. P. Alston, Report of the UN Special Rapporteur on Extreme Poverty and Human Rights, UN Doc. A/HRC/29/31 (2015); J. Linarelli, M. E. Salomon, and M. Sornarajah, *The misery of international law: Confrontations with injustice in the global economy* (Oxford: Oxford University Press, 2018), pp. 226–270; Moyn (2018, see note 6).
9. J. R. Oldfield (ed), *Civilization and black progress: Selected writings of Alexander Crummell on the South* (Charlottesville: University of Virginia Press, 1995), p. 164.

10. S. S. Amrith, *Decolonizing international health: India and Southeast Asia, 1930–65* (Basingstoke: Palgrave MacMillan, 2006); A. Bashford, *Global population: History, geopolitics, and life on earth* (New York: Columbia University Press, 2014); E. Boris and J. Klein, *Caring for America: Home health workers in the shadow of the welfare state* (New York: Oxford University Press, 2012); M. Cueto, T. M. Brown, and E. Fee, *The World Health Organization: A history* (Cambridge: Cambridge University Press, 2019).

11. J. Slaughter, "Hijacking human rights: Neoliberalism, the new historiography, and the end of the Third World," *Human Rights Quarterly* 40/4 (2018), pp. 735–775.

12. P. Ewick and S. Silbey, *The common place of law* (Chicago: University of Chicago Press, 1998), p. 20.

13. Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, UN Doc. E/C.12/2000/4 (2000), para. 11.

14. See, for example, J. Biehl, M. P. Socal, and J. J. Amon, "The judicialization of health and the quest for state accountability: Evidence from 1,262 lawsuits for access to medicines in Southern Brazil," *Health and Human Rights* 18/1 (2016), pp. 209–220; J. Biehl, M. P. Socal, V. Gauri, et al., "Judicialization 2.0: Understanding right-to-health litigation in real time," *Global Public Health* 14/2 (2018), pp. 190–199; L. B. Pizzarossa, K. Perehudoff, and J. C. Forte, "How the Uruguayan judiciary shapes access to high-priced medicines: A critique through the right to health lens," *Health and Human Rights* 20/1 (2018), pp. 93–105.

15. See, for example, B. M. Meier, "Making health a human right: The World Health Organization and the United Nations Programme on Human Rights and Scientific and Technological Developments," *Journal of the Historical Society* XIII/2 (2013), pp. 195–229.

16. T. Murphy, "AIDS," in J. Hohmann and D. Joyce (eds), *International law's objects* (Oxford: Oxford University Press, 2018), pp. 106–117.

17. See, for example, S. L. M. Davis and C. Mohamed, "Global rights, local risk: Community advocacy on the right to health in China," in T. Destrooper and S. E. Merry (eds), *Human rights transformation in practice* (Philadelphia: University of Pennsylvania Press, 2018), pp. 229–250.

18. L. O. Gostin, J. Monahan, J. Kaldor, et al., "The legal determinants of health: Harnessing the power of law for global health and sustainable development," *Lancet* 393/10183 (2019), pp. 1857–1910.

19. See relatedly C. A. Heimer and J. Morse, "Colonizing the clinic: The adventures of law in HIV treatment and research," in H. Klug and S. E. Merry (eds), *The new legal realism, volume II: Studying law globally* (New York: Cambridge University Press, 2016), pp. 69–95.

20. See, for example, P. Farmer, *Pathologies of power: Health, human rights, and the new war on the poor* (Berkeley: University of California Press, 2004); A. E. Yamin, *Power, suffering, and the struggle for dignity: Human rights frameworks for health and why they matter* (Philadelphia: University of Pennsylvania Press, 2017).

21. World Health Organization, *Positioning health in the post-2015 development agenda*, discussion paper (2012), p. 3. Available at https://www.who.int/topics/millennium_development_goals/post2015/WHOdiscussionpaper_October2012.pdf.

22. But see A. E. Yamin, *When misfortune becomes injustice: Evolving human rights struggles for health and social equality* (Stanford: Stanford University Press, forthcoming).

23. P. Hunt, "Interpreting the international right to health in a human rights-based approach to health," *Health and Human Rights* 18/2 (2016), pp. 109–130.

24. T. Murphy, "Hardwired human rights: A health and human rights perspective on global health law," in G. L. Burci and B. Toebes (eds), *Research handbook on global health law* (Cheltenham: Edward Elgar, 2018), pp. 82–103.

25. P. Alston, "Does the past matter? On the origins of human rights," *Harvard Law Review* 126/7 (2013), pp. 2043–2081.

26. T. Murphy and A. Müller, "The United Nations special procedures: Peopling human rights, peopling global health," in B. M. Meier and L. O. Gostin (eds), *Human rights in global health: Rights-based governance for a globalising world* (Oxford: Oxford University Press, 2018), pp. 487–508.

27. Destrooper and Merry (see note 17).

28. People's Health Movement, "Management consulting firms in global health," pp. 278–297. Available at https://phmovement.org/wp-content/uploads/2018/07/D3.pdf.

29. P. Hunt, "How to advance social rights without jeopardising the Human Rights Act 1998," *Political Quarterly* 90/3 (2019), pp. 393–401. See also P. Alston, Report of the Special Rapporteur on Extreme Poverty and Human Rights, UN Doc. A/HRC/32/31 (2016).

30. P. Piot, "Governance for the future of global health," *Lancet* 389/10066 (2017), p. 243.

31. See, in particular, A. Kapczynski, "The right to medicines in an age of neoliberalism," *Humanity* 10/1 (2019); and "Symposium: 'The right to medicines in an age of neoliberalism,'" *Humanity Blog* (October 4, 2019). Available at http://humanityjournal.org/symposium-the-right-to-medicines-in-an-age-of-neoliberalism/.

32. But see, for example, A. Chapman and J. Wyndham, "Human rights: A human right to science," *Science* 340/6138 (2013), p. 1291; O. De Schutter, "The right of everyone to enjoy the benefits of scientific progress and the right to food: From conflict to complementarity," *Human Rights Quarterly* 33/2 (2011), pp. 304–350.

33. Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (1997), ETS 164; UNESCO, Universal Declaration on the Human Genome and Human Rights (1997);

UNESCO, International Declaration on Human Genetic Data (2003); UN Declaration on Human Cloning (2005); UNESCO, Universal Declaration on Bioethics and Human Rights (2005).

34. But see P. Alston, Report of the Special Rapporteur on Extreme Poverty and Human Rights, UN Doc. A/74/493 (2019).

35. T. Murphy, "Legal literacy: An essential complement to digital and scientific literacy," United Nations Research Institute for Social Development (December 7, 2018). Available at http://www.unrisd.org/80256B3C005BE6B5/search/6C696D0B0D8577EEC125835C002E4DF9?OpenDocument.

36. C. Williams and P. Hunt, "Neglecting human rights: Accountability, data and Sustainable Development Goal 3," *International Journal of Human Rights* 21/8 (2017), pp. 1114–1143. See also L. McGregor, D. Murray, and V. Ng, "International human rights law as a framework for algorithmic accountability," *International and Comparative Law Quarterly* 68/2 (2019), pp. 309–343.

37. See generally F. Johns, *Non-legality in international law: Unruly law* (Cambridge: Cambridge University Press, 2013); H. Lindahl, *Fault lines of globalization: Legal order and the politics of a-legality* (Oxford: Oxford University Press, 2013); H. Lindahl, *Authority and the globalisation of inclusion and exclusion* (Cambridge: Cambridge University Press, 2018).

38. See "WHO unveils sweeping reforms in drive towards 'triple billion' targets" [press release], March 6, 2019. Available at https://www.who.int/news-room/detail/06-03-2019-who-unveils-sweeping-reforms-in-drive-towards-triple-billion-targets; J. Gibson, L. Forman, and S. Nixon (eds), "Special section on bioethics and the right to health," *Health and Human Rights Journal* 17/1 (2015), pp. 1–62; T. Murphy, "Judging bioethics and human rights," in M. K. Land and J. D. Aronson (eds), *New technologies for human rights law and practice* (New York: Cambridge University Press, 2017), pp. 71–92.

The Right(s) Road to Universal Health Coverage

HELENA NYGREN-KRUG

Abstract

The political momentum around universal health coverage (UHC) provides a welcome opportunity to scale up efforts to dismantle barriers to accessing health services and to create enabling environments for people to thrive and be healthy. However, UHC lacks sufficient clarity, both conceptually and operationally, to generate the societal transformation required to ensure its successful implementation in countries. This article argues that both the messaging and the monitoring and implementation guidance around UHC are ambiguous and flawed from a human rights perspective. To leverage the reforms necessary to achieve UHC, human rights norms and principles need to signpost the direction ahead, and human rights mechanisms need to be involved to enhance the accountability of those United Nations member states that choose to "take a wrong turn." The article argues that a human rights-based approach to programming offers a practical methodological framework for designing and implementing UHC at the national level. It concludes by illustrating five key areas in which it is critical to invoke human rights as the foundation for UHC and for which consistent, authoritative, and practical guidance is needed to support countries in getting onto the right(s) road to UHC.

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Disclaimer: The author is currently a staff member of UNAIDS and former staff member of the World Health Organization and the Office of the United Nations High Commissioner for Human Rights. The views expressed are those of the author and do not necessarily represent those of people, institutions, or organizations that the author may be associated with.

Introduction

Universal health coverage (UHC) has risen on the global health agenda since its adoption as a Sustainable Development Goal (SDG) target and now features prominently in the advocacy of global health institutions.[1] "All roads lead to universal health coverage," according to World Health Organization (WHO) Director-General Tedros Adhanom Ghebreyesus, who has made UHC the organization's top priority while considering UHC, ultimately, to be a political choice.[2]

UHC provides a welcome and unifying platform for the global health community to focus its efforts in the midst of competing priorities. However, its ability to leverage the reforms necessary in countries to achieve its intended purpose is hampered by its own ambiguity, which reflects a deeper failure to put people and their rights at the center of health and health systems. This failure has, in many countries, led to priorities being skewed away from poor, vulnerable, and marginalized communities; services not reaching deep and far enough; widespread out-of-pocket spending by patients; and rampant corruption.[3]

Addressing UHC requires grappling with a wide spectrum of laws, policies, and practices that reflect the willingness and capacity of governments to deliver on their commitments and meet their human rights obligations.[4] To secure meaningful progress, therefore, global health and development institutions leading efforts to support countries in implementing UHC must step up to the task of clarifying UHC and signposting the journey ahead, conceptually and operationally, in line with relevant human rights norms and principles.

Following this introduction, the first part of this article unpacks the assertion that UHC is rooted in a wider, longer, and deeper journey toward the realization of human rights, using various legal, historical, institutional, and social arguments. The second part briefly examines the current messaging and monitoring and implementation guidance around UHC from a human rights perspective. The third and last part argues that a human rights-based approach (HRBA) to programming provides a useful methodological framework for implementing UHC at the national level and concludes by highlighting five critical areas in which consistent, authoritative, and practical guidance is urgently needed to support countries in getting onto the right(s) road to UHC.[5]

The long and continuous road toward the realization of rights

The peoples of the United Nations have "reaffirmed their faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women and have determined to promote social progress and better standards of life in larger freedom."

—Universal Declaration of Human Rights, preamble

UHC and other SDGs and targets are critical milestones, or "an important step on the longer, and continuous, road towards the full and effective realization of all human rights for all."[6]

2030 Agenda rooted in human rights

UHC has been widely articulated across General Assembly and World Health Assembly resolutions in recent years.[7] Its formulation culminated in SDG target 3.8, which sets out the commitment of United Nations (UN) member states to "achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all."[8]

The 2030 Agenda for Sustainable Development, which builds on and expands from the Millennium Development Goals, can be characterized as a nonbinding consensual UN policy document to be interpreted in a manner consistent with the treaties and principles of international law.[9] In this regard, the 2030 Agenda sets out that the 17 SDGs and 169 targets "seek to realize the human rights of all," that the agenda is "grounded in the Universal Declaration of Human Rights [and] international human rights treaties," and that it is to be "implemented in a manner that is consistent with the rights and obligations of States under international law."[10]

Universal Declaration of Human Rights: The launching pad of UHC

UHC implicates a wide range of human rights, including the rights to life; health; security; equality and nondiscrimination; freedom of movement, association, and assembly; information; expression; privacy; participation; an adequate standard of living; food; water; adequate housing; education; social security; and access to the benefits of scientific progress. These and other rights are enshrined in international and regional treaties and in national constitutions, and they also form part of customary international law. Overall, they can be traced back to the Universal Declaration of Human Rights, which established the normative foundation for the international human rights movement.[11]

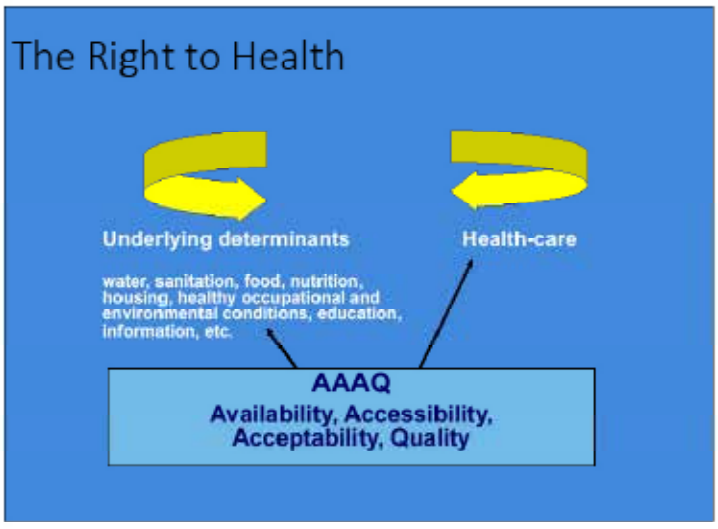
The Universal Declaration of Human Rights was adopted in the aftermath of the Second World War, shortly after the creation of the UN, of which human rights form part of its foundational purposes.[12] In this spirit, the WHO Constitution (1946) set out the enjoyment of the highest attainable standard of health as a human right.[13] During this period, many industrialized countries emerging from the devastation of the war established their health systems (for example, France in 1945, Japan in 1951, and the United Kingdom in 1948). Today, these systems are integral to the wider governance of society as reflected in the Alma-Ata and Astana declarations on primary health care, which reaffirm governments' responsibility to promote the health of their people and which refer to health as a human right.[14] Furthermore, ample legislation and jurisprudence testify how human rights norms and principles should permeate national health systems and set parameters for what governments, as the stewards of these systems, can and should do, as well as what they are not permitted to do.[15]

Knitting UHC into the right to health

General Assembly and World Health Assembly resolutions adopted on UHC over the years have consistently reiterated how human rights—particularly the right to health—provide the overarching framework for UHC.[16] To give a recent example, the first operative paragraph of the political declaration adopted at the high-level meeting on UHC reaffirms health as a human right.[17] In a similar vein, the UN Special Rapporteur on the right to health has emphasized that UHC must be understood as consistent with the right to health.[18]

General Comment 14 adopted by the UN Com-

FIGURE 1. Normative scope and content of the right to health



Source: Office of the United Nations High Commissioner for Human Rights and World Health Organization, *The right to health: Fact sheet no. 31* (June 2008). Available at http://www.ohchr.org/Documents/Publications/Factsheet31.pdf.

mittee on Economic, Social and Cultural Rights in 2000 provides an authoritative interpretation of the normative scope and content of the right to health (Figure 1).[19] As such, it can be considered to flesh out the constitutional provision of WHO on the right to health while underscoring WHO's role in supporting the realization of the right to health through "the formulation of health policies, or the implementation of health programmes."[20]

The concept of UHC, in turn, is rooted in the WHO secretariat's efforts to address health financing as a basic building block of a strong and well-performing health system. Interestingly, WHO's framework for monitoring health systems' performance was developed in parallel with the drafting of General Comment 14. The WHO secretariat attempted to forge synergies by providing input into the drafting of General Comment 14 and, conversely, integrating critical aspects of the right to health into its measurement strategy for health systems around access, utilization, quality, and effective coverage.[21] Moreover, WHO's health systems indicators were drawn on in the identification of appropriate indicators to monitor the realization of the right to health.[22]

UHC in "human rights terms"

The first two letters in the acronym UHC can be easily defined using international instruments. "Universal" in the Universal Declaration of Human Rights clearly means everyone, and "health" is defined broadly in WHO's Constitution.[23] While the word "coverage" is often interpreted in accordance with American English usage to refer to insurance, its origin—"cover"—resonates with protection, a fundamental human rights principle.[24] As such, "coverage" is linked to social protection under SDG 1.3, which is, in turn, anchored in the human right to social security.[25] The Committee on Economic, Social and Cultural Rights has interpreted "coverage" to mean that "all persons are covered by the social security system, especially individuals belonging to the most disadvantaged and marginalized groups without discrimination" and has noted that noncontributory schemes are necessary to ensure "universal coverage."[26]

The risk of sliding down narrow and slippery paths

"If you don't know where you're going, any road will get you there."

—*Lewis Carroll*

Current guidance and messaging around UHC reveal incoherence in terms of how UHC is understood, in addition to numerous human rights deficits, which will inevitably hamper countries' ability to leverage the structural reforms necessary for its achievement.

Stuck in a box

Guidance on UHC implementation tends to jump right into the question of "financial risk protection" rather than focusing on UHC writ large. Moreover, the debate around progress toward UHC implementation often starts on a negative footing that assumes difficult financing decisions.[27] In fact, UHC is often associated with a box (Figure 2) depicting trade-offs among the proportions of the population to be covered, the range of services to be made available, and the proportion of the total costs to be met.[28]

In this context, the human rights principle of progressive realization has been extracted from other interrelated norms and principles and is applied to describe what are considered "policy choices."[29] This negates other interrelated human rights principles relevant to any priority-setting exercise, such as nonretrogression, minimum core content, maximum available resources, international assistance and cooperation, and equality and nondiscrimination.[30] It also disregards the process for setting priorities, which is equally important from a rights perspective and must be transparent, participatory (involving affected communities and other rights holders), and guided by an HRBA to programming (see the last section of this article).[31]

By diving into this "box," the analysis misses the crucial opportunity to explore why needs and rights are not being met or realized in the first place, and it also fails to allow for an expansive interpretation of UHC that goes beyond the issue of health sector resources. The box accepts an unfortunate (and oftentimes unacceptable) status quo: the fact

that a variety of technologies, goods, and services are unaffordable. In this context, and as an example, case studies illustrating how to make trade-offs include an agonizing account of whether to include hepatitis B treatment in UHC, thus implicitly accepting its exorbitant price as a given.[32] Just imagine where we would be with the AIDS epidemic today if prices of antiretroviral medicines had not been questioned and the injustice of unaffordable medicines not acted on through strategic litigation and other strategies.[33] Consider, moreover, how investing in expanding hepatitis B treatment ultimately saves costs in the long run by reducing long-term medical expenses for liver cancer and cirrhosis.[34]

Why not measure what we treasure?

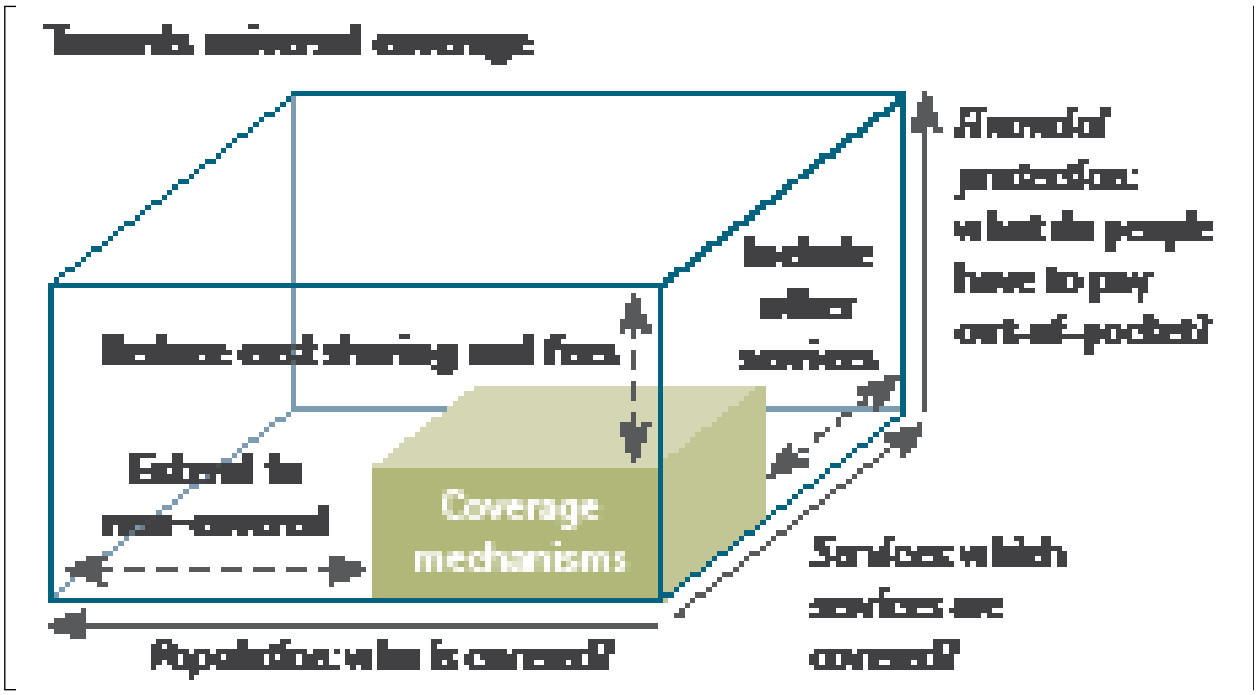
Several human rights considerations arise in relation to the monitoring of UHC. The two indicators adopted by the United Nations Statistical Commission in March 2017 for UHC are as follows:

> *3.8.1 Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population).*
> *3.8.2 Proportion of population with large household expenditures on health as a share of total household expenditure or income.*[35]

Firstly, the global indicator framework for the 2030 Agenda supports efforts to ensure equality and nondiscrimination by calling for indicators to be disaggregated.[36] WHO reports, however, that "because of the lack of data, it is not yet possible to compare the UHC service coverage index across key dimensions of inequality."[37] Another observation is that despite target 3.8's explicit reference to access to essential medicines, WHO's extensive experience in monitoring this aspect of UHC, and the fact that access to essential medicines is a core obligation of the right to health, neither of the indicators mentions essential medicines.[38]

Several questions from a rights perspective arise in relation to indicator 3.8.2, starting with its focus on "households," which can mask significant power differentials that reflect entrenched patterns of discrimination in society at large. Evidence

FIGURE 2. The three dimensions (policy choices) of UHC



Source: World Health Organization, *Universal coverage: Three dimensions*. Available at http://www.who.int/health_financing/strategy/dimensions/en.

reveals that labeling a household as rich or poor, moreover, is an oversimplification and masks "intrahousehold inequality," which often hits children hardest.[39] While practical from a measurement point of view, household expenditure will not help track key human rights dimensions, such as gender equality, in the context of UHC and risks missing vulnerable household members such as persons with mental or physical disabilities.

More fundamentally, the way that 3.8.2. is formulated incorporates an assumption of how societies are structured, with households paying for health care (while also supposing that "health" means "health care"). This echoes an underlying view of health as a commodity or individual responsibility, which is problematic from a rights perspective. Studies have demonstrated, furthermore, that to reduce catastrophic payment incidence, the share of total health expenditure that is prepaid needs to be increased, particularly through taxes and mandatory contributions.[40] Ironically, in this regard, the indicators risk being irrelevant or difficult to measure for countries that ensure the most health expenditure through taxes.[41]

To ensure a more holistic monitoring approach to UHC, it is critical to underscore the interconnectedness and interdependence of human rights and their respective linkages to various SDGs. For instance, SDG 16—which addresses several human rights-related issues, such as democratic governance, the rule of law, access to justice, and personal security—is increasingly becoming central to national planning, budgeting, and reporting in some African countries (for example, Ghana and Benin are emphasizing budget spending that has a high SDG 16 impact).[42]

Inconsistent messaging

In contrast to the relatively narrow and technical exercises of UHC indicators and guidance, the advocacy around UHC is increasingly dispersed and all-encompassing, with the global health community advocating for UHC as the pathway to numerous other SDG-health targets and issues, from diseases to wider prevention efforts and actions to address the underlying determinants of health.[43]

According to WHO, UHC means that "all individuals and communities receive the health services they need without suffering financial hardship."[44] In contrast to this rather top-down and passive formulation, in another publication WHO describes UHC as an active subject that "delivers disease prevention, health promotion, and treatment for communicable and noncommunicable diseases alike."[45] In other words, the way that UHC is referred to is circular, with "UHC delivering UHC."

Messaging around UHC and human rights has added to the confusion around UHC's scope and content. Interpretations vary: At one end of the spectrum is WHO's director-general asserting that "universal health coverage is a human right," thus assuming a new self-standing human right to UHC.[46] At the other end, WHO has published a policy brief on "what policy makers should keep in mind if they want to use UHC as a way to promote the right to health," sending the message that UHC is somehow separate from, and outside of, the realm of human rights and that governments can choose to implement UHC in isolation from their human rights obligations.[47]

The need to signpost the journey ahead

"Action without vision is only passing time, vision without action is merely day dreaming, but vision with action can change the world."

—Nelson Mandela

The vision of UHC anchored in human rights norms and principles is expansive and helps provide clarity in interpreting UHC. It would be timely to translate it into clear and coherent messaging as well as firm and thoughtful normative guidance to support countries. In this regard, a human rights-based approach to programming provides a practical methodological framework for designing and implementing UHC at the national level. While several areas are ripe for attention and need to be included in such a roadmap, five interrelated ones can help us illustrate the way forward:

1. Government in the driver's seat but all eyes on the road

While the government is the prime duty bearer under international human rights law and has a legitimate place in the driver's seat, a strong and vibrant civil society needs to occupy a front seat in the journey toward UHC. Activism needs to be nurtured, not least among young people, who need to be at the helm of UHC implementation. To exercise their essential functions—including those of advocate, watchdog, whistle-blower, and service provider—civil society organizations require support in light of the growing number of countries that are passing restrictive legislation to prevent or deter them from performing their work.[48] They will also need to help convene and facilitate coalition building across wider movements dedicated to specific health issues (such as HIV, tuberculosis, mental health, and noncommunicable diseases) and those representing specific population groups.[49] This process of cultivating active agents of change for UHC from within the societies in which they live will be key to success.

Working hand in hand with civil society, affected communities, and other relevant stakeholders, governments can initiate the journey by doing a thorough situational analysis using an HRBA to programming, which starts by assessing the health needs and rights of individuals and groups in light of constitutional and international human rights obligations.[50] Process is central in an HRBA, and several human rights principles—such as freedom of association, which has a long history in supporting the realization of social rights—are relevant. As an illustration, consider how the freedom of association, when legalized in France in 1884, led to a social dialogue from which workers were able to claim their social rights at the enterprise and national levels.[51] Today, many of these principles, such as the right to participation, are enshrined not only in national laws but also at the provincial level (for example, the Kisumu County Public Participation Act of 2015 in Kenya) and at times establish mechanisms such as committees for community participation in health (for example, Law No. 100 of 1993 in Colombia).[52]

Using an HRBA to programming helps identify a spectrum of bottlenecks to UHC implementation, as it considers the roles of rights holders and duty bearers. A lack of political will from duty bearers, for example, may be found to be rooted in an entrenched lack of motivation among the governing elite for various reasons, such as their own ability to travel abroad whenever requiring medical treatment.[53] Working closely with civil society organizations and the wider human rights community, efforts to support UHC implementation can include ensuring that those countries that "stray off the road"—for example, by joining forces with, or bowing to, powerful interests—are held to account for failing to fulfill their human rights obligations.

The 2030 Agenda, with its voluntary national reviews and peer-reviewed soft guidance, lacks an accountability framework. This is where human rights not only offer a legal basis and guidance in the implementation of UHC but also a plethora of mechanisms to enhance accountability, including national human rights institutions, ombudspersons, parliamentary committees, and courts. National constitutions supported by legislation can play a central role in realizing the rights to social security, health, and equality, and when articulated as explicit entitlements grounded in law, they can sustain across time as governments come and go.[54] UHC will need to be reflected in national laws—and this is perhaps the most critical phase, as legislation often ultimately determines who will benefit from health coverage and how.[55] Litigation can then be an effective strategy for highlighting health system failures and challenging discriminatory historical structures and hierarchies, thereby spurring broader social, economic, and political change.[56]

At the global and regional levels, mechanisms include UN human rights treaty bodies, which monitor states' compliance with treaty implementation; optional protocols, which allow individuals to petition governments; and the Special Procedures and Universal Periodic Review of the UN Human Rights Council. Human rights monitoring mechanisms are already and systematically pointing out inconsistencies as countries come up for scrutiny when it comes to UHC implementation. The Committee on Economic, Social and Cultural Rights, for example, has expressed concern about

South Africa's attempts to achieve UHC through its National Health Insurance Bill, which excluded non-nationals.[57]

2. Reach the furthest behind first

"Universal" means everyone; however, WHO advises countries to pursue at least "a minimum of 80% population coverage of essential health services" and asserts that "all countries can reach some level of universality."[58] A review of experiences from Indonesia, Kenya, Uganda, and Ukraine in integrating HIV treatment into UHC revealed how the 20% who are not covered likely include marginalized people, in particular key populations stigmatized and criminalized because of their HIV status, sexual orientation, gender identity, behavior (for example, drug use), or occupation (for example, sex workers).[59]

The HIV response has revealed how punitive laws, discrimination, and other forms of exclusion fuel vulnerability to disease, poverty, and ill-health and how, in corollary, the ability of affected communities to protect themselves or survive HIV clearly depends on their ability to exercise their rights.[60] UNAIDS is now calling for lessons of the HIV response to be applied to efforts to achieve UHC.[61] Importantly, in the 2030 Agenda, UN member states have committed "to endeavour to reach the furthest behind first."[62] In this spirit, UNICEF advocates for actions toward UHC to first address the needs of those currently left behind, given that these populations often have the least political voice.[63]

Redressing de facto discrimination and achieving substantive equality may require states to adopt special measures.[64] For instance, in the context of its state reporting to the Committee on the Elimination of Racial Discrimination, the United States was urged to

> *take concrete measures to ensure that all individuals, in particular those belonging to racial and ethnic minorities who reside in states that have opted out of the Affordable Care Act, undocumented immigrants and immigrants and their families who have been residing lawfully in the United States for less than five years, have effective access to affordable and adequate health-care services.*[65]

WHO and other UN agencies must be consistent and forceful in their messaging so that "universal" is clearly understood to mean everyone. In other words, the journey to UHC needs to start by reaching those left furthest behind while stepping up support to states for civil registration and vital statistics systems and other relevant tools.[66]

3. Strap the private sector firmly into the backseat

The operationalization of UHC is currently underway in a muddied playing field of diverse stakeholders pursuing different agendas. Among these stakeholders are powerful private sector actors with high stakes in how UHC is interpreted and implemented. These actors include insurance companies, health care providers, and pharmaceutical companies, for which, evidently, UHC can help boost revenue and stock value, which heightens the risk that its ambiguities are exploited to push for a market- and (private) insurance-driven model.[67] The ability of such actors to influence the interpretation and implementation of UHC (often through governments) should not be underestimated. For example, in the United States, Big Pharma tops the lists for US campaign contributions and lobbying dollars, with the industry spending US$28 million in 2018 on lobbying, and the pharmaceutical and health products industry overall spending US$280 million in 2018 to influence federal policy.[68]

At the international level, many private sector actors are already shaping the public health agenda, often under the umbrella of public-private partnerships or in more subtle but sophisticated ways.[69] At the national level, moreover, these partnerships are growing, including in low-income countries such as Uganda, where efforts by civil society to promote the accountability of public-private partnerships have been undermined by a lack of information, transparency, participation, and remedial mechanisms.[70] In this regard, the African Commission on Human and Peoples' Rights recently adopted a resolution expressing concern about "the current trend amongst bilateral donors and international

institutions of putting '*pressure on States Parties to privatize or facilitate access to private actors in their health and education sectors.*"[71] As the UN Special Rapporteur on the right to health observed in his mission report on Algeria:

> *owing to the quality of care provided in the public sector and the dissatisfaction of service users, the private sector was growing fast and in an unregulated manner. This was leading to a dual system that offered better quality care for those who could afford to pay out of pocket or travel abroad to be treated, thereby increasing inequalities in access to health care.*[72]

General Comment 24 of the Committee on Economic, Social and Cultural Rights calls on states to subject private providers to strict regulations that prohibit them from denying access to affordable and adequate services, treatments, or information.[73] States need support in operationalizing relevant human rights standards, such as those set out in the Guiding Principles on Business and Human Rights, which UN member states endorsed as part of the 2030 Agenda.[74] The field of education provides inspiration: for example, the recently adopted Abidjan Principles provide guidance in the context of the rapid expansion of private sector involvement in education.[75] Another initiative from the field of education is the recent commitment undertaken by the board of the Global Partnership for Education not to support for-profit provision of core education services.[76]

WHO has experience in supporting states in their regulation of the private sector. Two examples are the implementation of the WHO Framework Convention on Tobacco Control and the 1981 International Code of Marketing of Breast-milk Substitutes.[77] It is imperative that WHO step up its support to states in this area in the context of UHC. Guidance and mechanisms to tackle conflicts of interest, secure access to justice, and ensure effective remedies when private actors are responsible for violating health-related human rights are urgently needed. At present, civil society organizations are taking on this tremendously important task without the requisite engagement, leadership, and support from WHO, the World Bank, and other leading actors in the field of UHC.[78]

4. Stay on course and don't divert down narrow paths

UHC was conceptualized in the context of states' recognition of health as a foreign policy issue, inviting a multisectoral approach.[79] In line with the expansive definition of health, and in support of the realization of the right to health, UHC extends beyond the health sector to the underlying determinants of health. These determinants include access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.[80]

When it comes to health care specifically, an expansive interpretation is required, starting at the community level with primary care in an integrated, coordinated, community-oriented, and person-focused care system.[81] An HRBA situational analysis, with affected communities at the forefront, can help determine what services are deemed priority and what barriers exist to making them available. "Availability"—the initial "A" in the AAAQ framework, which underpins the right to health—addresses the question whether health personnel, medicines, and facilities are in place in the first place. Sobering statistics (from 2013 to 2018) indicate that all least developed countries had fewer than 10 medical doctors and fewer than 5 dentists and 5 pharmacists per 10,000 people, and 98% had fewer than 40 nursing and midwifery personnel per 10,000 people.[82] To illustrate how stark these numbers really are, contrast the average of 3.1 medical doctors per 10,000 people in low-income countries with the global average of 15.1 per 10,000 and with the fact that high-income countries have twice the global average.[83] A lesson learned from the HIV response, in this context, has been the engagement of community health workers as part of wider community health systems; these workers are often better placed to reach people who are being left behind due to prejudice, poverty, punitive

laws, or geographical distance.[84]

5. Tackle roadblocks and replenish

An HRBA to programming can help unpack whether and in what way the government lacks capacity or is unwilling to meet its human rights obligations. It can reveal numerous barriers to UHC beyond those traditionally considered financial barriers, addressing related costs such as transportation to facilities or corruption. In relation to the latter, for example, a recent study across 34 African countries found that more than one in four people who accessed public services, such as health care and education, paid a bribe in the preceding year, and that the poorest people were twice as likely to pay a bribe as the richest people.[85]

Critically, an HRBA allows the analysis to go "upstream" to consider harmful and punitive laws, policies, and practices that oftentimes may require political will to reform yet may require minimal financial resources to change. An example is spousal consent in order for women to access sexual and reproductive health services, which is required in 29 countries.[86] Another is how across 19 countries, HIV status has been found to have resulted in approximately one in five people living with HIV having been denied health care (including dental care, family planning services, and sexual and reproductive health services).[87] By exposing and addressing barriers beyond just the financial ones, the journey toward UHC will move faster and help ensure that gaps among different populations are not widened.

Human rights obligations, including the obligation to fulfill (which requires states to adopt appropriate legislative, administrative, budgetary, judicial, promotional, and other measures), bind the government as a whole—in other words, ministries of finance, planning, and trade are equally accountable as the ministry of health when it comes to advancing UHC.[88] In our complex and interdependent world, governments need to navigate and defend the right to health among a myriad of push-and-pull factors that take many different shapes and forms, from trade agreements to investment treaties. Moreover, there is a pressing need to go beyond traditional sources of aid and trade and address structural causes that are blocking financing for sustainable development, from a heavy debt burden on countries to illicit financial flows.

Prioritizing reliable domestic financing is a prerequisite to sustain the gains made toward UHC and may require tax reform. Too often, valuable resources are being diverted from states; the International Monetary Fund alerts that developing countries are most affected by corporate base erosion and profit shifting, generating losses of 1.3% of GDP for non-OECD countries.[89] The tax burden often shifts from multinational enterprises to small and medium enterprises, and to the rest of the population via indirect regressive taxes such as value-added taxes, which have a particularly negative impact on women and marginalized groups.[90] Another sobering statistic is that only US$0.04 of every US$1 of tax revenue comes from taxes on wealth.[91] Undertaxing the richest segments of the population leads to the underfunding of public services, which are then often outsourced to private companies that exclude the poorest.[92] As Jeffrey Sachs has noted, a 1% net worth tax on billionaires could in principle fund both UHC and universal education access in low-income countries.[93]

Finally, and to end on a positive note, the transformative 2030 Agenda creates exciting new opportunities to explore win-win scenarios across the SDGs, including health and the environment. In relation to financing, for example, the Nigerian Sustainable Finance Roadmap lists health as the first of its examples of sustainability-related factors that could influence an alternative future growth trajectory, noting how air pollution costs the Nigerian economy 1% of gross national income.[94] With increasing awareness of the tremendous health impacts of clean air, access to clean water and adequate sanitation, healthy and sustainable food, a safe climate, and healthy biodiversity and ecosystems, creative ways of working across sectors can allow for a dynamic interaction that shifts the focus in UHC to prevention, embracing the expansive scope of the right to health and its interrelatedness and interdependence with other human rights.

Conclusion

Powerlessness, discrimination, inequality, and accountability failures that lead to ill-health and poverty are politically driven and deeply rooted. As a result, the struggle to achieve UHC is inherently political. UHC is not a political "choice," however, nor do "all roads lead to UHC." UHC is a human right imperative, and countries urgently need support to get onto the right(s) road to UHC.

As the custodian of the 2030 Agenda and guardian of human rights, the UN is well-placed to articulate how human rights norms and principles provide explicit parameters for UHC implementation. Within and beyond the UN, moreover, 12 multilateral global health agencies have recently pledged to work together to accelerate country progress on the health-related SDG targets.[95] Another relevant initiative is UHC2030, which aims to inform collaboration on UHC and includes a civil society engagement mechanism.[96] Whichever platform or mechanism is used, WHO, the World Bank, and other agencies involved in UHC implementation must urgently step up efforts to ensure that it promotes, reinforces, and furthers the realization of human rights.

Operational guidance that builds on lessons learned from the HIV response and uses an HRBA to programming should be developed and provided to support countries in their implementation of UHC.[97] Otherwise, as warned by the UN Special Rapporteur on the right to health, there is a real danger of countries forging ahead with UHC implementation in a way that is disconnected from their human rights obligations.[98] We cannot afford to repeat this mistake from the Millennium Development Goal era.[99] The hardwiring of human rights in the SDGs needs to be activated as a potentially powerful corrective to counter the risk of UHC implementation sliding down a narrow and dangerous path where vested interests prevail and the most vulnerable and marginalized are left behind.[100] Addressing UHC as a human rights imperative—with human rights norms and principles providing explicit and nonnegotiable parameters for moving forward—will help energize, support, and speed up the journey ahead, as well as ensure that it is inclusive and transformative.

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References

1. See, for example, J. Kirton and I. Kickbusch (eds), *Health: A political choice* (2019). Available at http://edition.pagesuite.com/html5/reader/production/default.aspx?pubname=&edid=1b1471a7-7575-4371-9969-9e93f7dd4aa8.

2. T. Ghebreyesus, "All roads lead to universal health coverage," *Lancet Global Health* 5/9 (2017), pp. 839–840.

3. M. Sidibé, H. Nygren-Krug, B. McBride, et al., "The future of global governance for health: Putting rights at the center of sustainable development, *Oxford Scholarship Online* (2018). Available at http://www.oxfordscholarship.com/view/10.1093/oso/9780190672676.001.0001/oso-9780190672676-chapter-5.

4. I. Saiz, "Rising inequality is a wake-up call for human rights, the challenges that economic inequality poses for human rights are not the death knell for the movement but a wake-up call for a more holistic approach," *Open Global Rights* (May 29, 2018). Available at http://www.openglobalrights.org/rising-inequality-is-a-wake-up-call-for-human-rights/.

5. See United Nations Sustainable Development Group, *Human rights*. Available at http://undg.org/human-rights/; see also World Health Organization, *A human rights-based approach to health*. Available at http://www.who.int/hhr/news/hrba_to_health2.pdf.

6. *Joint statement of the chairpersons of the UN human rights treaty bodies on the post-2015 development agenda* (May 2013).

7. See, for example, General Assembly, G.A. Res. 74/2, UN Doc. A/RES/74/2 (2019); General Assembly, G.A. Res. 73/337, UN Doc. A/RES/73/337 (2019); General Assembly, G.A. Res. 73/131, UN Doc. A/RES/73/131 (2019); General Assembly, G.A. Res. 72/139, UN Doc. A/RES/72/139 (2018); General Assembly, G.A. Res. 72/108, UN Doc. A/RES/72/138 (2018).

8. General Assembly, G.A. Res. 70/1, UN Doc. A/RES/70/1 (2015).

9. See, for example, United Nations, Statute of the International Court of Justice (1946), art. 38; Vienna Convention on the Law of Treaties (1969).

10. General Assembly, G.A. Res. 70/1 (see note 8), preamble, paras. 10, 18.

11. Universal Declaration of Human Rights, G.A. Res. 217 A (III) (1948).

12. Charter of the United Nations (1945), art. 1.

13. General Assembly, Entry into Force of the Constitution of the World Health Organization, UN Doc. A/RES/131 (1947); Constitution of the World Health Organization (1946).

14. International Conference on Primary Health Care: Declaration of Alma-Ata, Alma-Ata, September 6–12, 1978; Global Conference on Primary Health Care: Declaration on Primary Health Care, Astana, October 26, 2018.

15. See *Global health and human rights database*. Available at http://www.globalhealthrights.org/category/health-topics/health-care-and-health-services.

16. General Assembly, G.A. Res. 67/81, UN Doc. A/RES/67/81 (2013). See also note 7.

17. General Assembly, "Universal health coverage: Moving together to build a healthier world" (adopted September 23, 2019, at the High-Level Meeting on Universal Health Coverage).

18. D. Puras, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN Doc. A/71/304 (2016), para. 78.

19. Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, UN Doc. E/C.12/2000/4 (2000).

20. Ibid., paras. 1, 4, 12, 63.

21. B. Shangelia, A. Tandon, O. B. Adams, and C. J Murray, "Access, utilization, quality, and effective coverage: An integrated conceptual framework and measurement strategy," *Social Science and Medicine* 61 (2005), pp. 97–109.

22. United Nations, *Human rights indicators: A guide to measurement and implementation*, UN Doc. HR/PUB/12/5 (2012).

23. Universal Declaration of Human Rights, G.A. Res. 217A (III)(1948), arts. 1, 2; Constitution of the World Health Organization (1946), preamble.

24. See Lexico, *Coverage*. Available at http://en.oxforddictionaries.com/definition/coverage.

25. 101st session of the International Labour Conference Geneva, *R202 – Social protection floors recommendation*, June 14, 2012. Available at http://www.ilo.org/dyn/normlex/en/f?p=1000:12100:0::NO::P12100_INSTRUMENT_ID:3065524.

26. Committee on Economic, Social and Cultural Rights, General Comment No. 19, The Right to Social Security, UN Doc. E/C.12/GC/19 (2008).

27. M. Chan, "Making fair choices on the path to universal health coverage," *Health Systems and Reform* 2 (2016), pp. 5–7.

28. World Health Organization, *Health systems financing: The path to universal health coverage* (Geneva: World Health Organization, 2010), fig. 2.

29. World Health Organization and International Bank for Reconstruction and Development/World Bank, *Monitoring progress towards universal health coverage at country and global levels: Frameworks, measures and targets* (2014).

30. Office of the United Nations High Commissioner for Human Rights, *Frequently asked questions on economic, social and cultural rights*. Available at http://www.ohchr.org/Documents/Issues/ESCR/FAQ%20on%20ESCR-en.pdf.

31. World Health Organization, *A human rights-based approach to health* (see note 5).

32. A. Voorhoeve, T. Edejer, L. Kapiriri, et al., "Three case studies in making fair choices on the path to universal health coverage," *Health and Human Rights Journal* 18/2 (2016), pp. 11–22.

33. UNAIDS, *How AIDS changed everything* (2015). Available at http://www.unaids.org/en/resources/campaigns/HowAIDSchangedeverything.

34. M. Barnhart, "A convenient truth: Cost of medications need not be a barrier to hepatitis B treatment," *Global Health Science and Practice* 4 (2016), pp.186–190.

35. General Assembly, G.A. Res. 71/313, UN Doc. A/RES/71/313 (2017).

36. Ibid.

37. World Health Organization and International Bank for Reconstruction and Development, *Tracking universal health coverage: 2017 Global monitoring report* (2017).

38. World Health Organization, *Access to essential medicines* (2010). Available at http://www.who.int/health-info/systems/WHO_MBHSS_2010_section4_web.pdf; World Health Organization, *WHO Model lists of essential medicines*. Available at http://www.who.int/medicines/publications/essentialmedicines/en/.

39. United Nations Development Programme and Oxford Poverty and Human Development Initiative, *Global multidimensional poverty index 2019: Illuminating inequalities* (2019). Available at http://hdr.undp.org/sites/default/files/mpi_2019_publication.pdf.

40. A. Wagstaff, G. Flores, J. Hsu, et al., "Progress on catastrophic health spending in 133 countries: A retrospective observational study," *Lancet Global Health* 6 (2017) pp. e169–e179.

41. See Ministry of Foreign Affairs and Ministry of Health and Social Affairs Sweden, *Sweden's work on global health: Implementing the 2030 Agenda* (Stockholm: Government Offices of Sweden, 2018), p. 39.

42. M. Laberge, "How Africa measures up on governance," *Project Syndicate* (July 18, 2019). Available at http://www.project-syndicate.org/commentary/africa-data-measuring-governance-progress-by-marie-laberge-2019-07.

43. Kirton and Kickbusch (see note 1).

44. See World Health Organization, *Questions and answers on universal health coverage*. Available at http://www.who.int/healthsystems/topics/financing/uhc_qa/en/.

45. World Health Organization, *Together on the road to universal health coverage: A call to action* (Geneva: World Health Organization, 2017).

46. T. Adhanom Ghebreyesus, "All roads lead to universal health coverage," *Lancet Global Health* 5/9 (2017), pp. e839–

e840.

47. World Health Organization, *Anchoring universal health coverage in the right to health: What difference would it make?* (Geneva: World Health Organization, 2015).

48. C. Swiney, "Undemocratic civil society laws are appearing in democracies," *Open Global Rights* (March 28, 2019). Available at http://www.openglobalrights.org/undemocratic-civil-society-laws-are-appearing-in-democracies-too/.

49. UNAIDS, Report by the NGO Representative (2019). Available at: https://www.unaids.org/sites/default/files/media_asset/21112019_UNAIDS_PCB45_NGO_Report_EN.pdf.

50. Kisumu Civil Society Organization, "UHC conference position paper" (July, 18 2019). Available at http://www.kelinkenya.org/wp-content/uploads/2019/05/UHC-Position-Statement-by-Kisumu-CSO-at-the-3rd-UHC-Conference_17052019.pdf.

51. See the International Labour Organization, *100 years of social protection: The road to universal social protection systems and floors* (Geneva: International Labour Organization, 2019), p. 16.

52. Republic of Kenya, *Kisumu Country Public Participation Act* (2015); Colombia, *Ley 100 de 1993* (1993), art. 2.10.1.1.8.

53. Y. Kazeem, "Africa's presidents keep going abroad for medical treatment rather than fixing healthcare at home," *Quartz Africa* (June 30, 2017). Available at http://qz.com/africa/1017973/zimbabwes-mugabe-and-nigerias-buhari-are-two-of-africas-sick-leaders-going-to-hospitals-abroad; G. Mwonzora, "Political will or not? The right to health in Zimbabwe in the era of SDGs," *Impakter* (March 7, 2019). Available at http://impakter.com/the-right-to-health-in-zimbabwe/.

54. International Labour Organization (see note 51), p. 25.

55. R. Magnusson, "Advancing the right to health: The vital role of law," *Sydney Law School Research Paper* 17/43 (2017).

56. J. T. Dunn, K. Lesyna, and A. Zaret, "The role of human rights litigation in improving access to reproductive health care and achieving reductions in maternal mortality," *BMC Pregnancy and Childbirth* 17 (2017).

57. Committee on Economic, Social and Cultural Rights, Concluding Observations: South Africa, UN Doc. E/C.12/ZAF/CO/1 (2018).

58. World Health Organization, *Together on the road to universal health coverage: A call to action* (Geneva: World Health Organization , 2017), p. 10.

59. PITCH, *Towards transformative integration of the HIV/AIDS response into Universal Health Coverage: Building on the strengths and successes of the HIV and AIDS response* (2019), p. 6.

60. H. Nygren Krug, "The Joint United Nations Programme on HIV/AIDS: With communities for human rights," in B. Mason Meier and L. O. Gostin (eds), *Human rights in global health* (New York: Oxford University Press, 2018).

61. UNAIDS, *Delivering on SDG3: Strengthening and integrating comprehensive HIV responses into sustainable health systems for Universal Health Coverage* (Geneva: UNAIDS, 2019).

62. General Assembly, G.A. Res. 70/1 (see note 8), para 4.

63. UNICEF, *The UNICEF health systems strengthening approach* (New York: UNICEF, 2016), p. 43.

64. Committee on Economic, Social and Cultural Rights, General Comment No. 20, Non-discrimination in Economic, Social and Cultural Rights, UN Doc. E/C.12/GC/20 (2009), art. 2(2).

65. Committee on the Elimination of Racial Discrimination, Concluding Observations: United States of America, UN Doc. CERD/C/USA/CO/7-9 (2014).

66. Global Financing Facility and the World Bank Group, *Civil registration and vital statistics fact sheet*, Available at http://www.globalfinancingfacility.org/sites/gff_new/files/documents/CRVS-GFF-FactSheet-EN.pdf.

67. Parroting the Right. Available at http://parrotingtheright.org/.

68. L. A. Caldwell, "Senators publicly grill 'Big Pharma' executives after accepting millions from industry," *NBC News Digital* (February 26, 2019). Available at http://www.nbcnews.com/politics/congress/senate-testimony-pharma-executive-admits-drug-prices-hit-poor-hardest-n976346?cid=sm_npd_nn_tw_ma.

69. J. Richter, "Public-private partnerships for health: A trend with no alternatives?," *Society for International Development* 47/2 (2004), pp. 43–48.

70. Initiative for Social and Economic Rights, *Achieving equity in health: Are public private partnerships the solution?* (Kampala: Initiative for Social and Economic Rights, 2019).

71. African Commission on Human and Peoples' Rights, Resolution on States' Obligation to Regulate Private Actors Involved in the Provision of Health and Education Services, Res. 420 (LXIV) (2019).

72. Human Rights Council, Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health on His Visit to Algeria, UN Doc. A/HRC/35/21/Add.1 (2017).

73. Committee on Economic, Social and Cultural Rights, General Comment No. 24, State Obligations under the International Covenant on Economic, Social and Cultural Rights in the Context of Business Activities, UN Doc. E/C.12/GC/24 (2017).

74. General Assembly, G.A. Res. 70/1 (see note 8); Office of the United Nations High Commissioner for Human Rights, *Guiding principles on business and human rights* (Geneva: Office of the United Nations High Commissioner for Human Rights, 2011).

75. *The Abidjan Principles: Guiding principles on the human rights obligations of states to provide public education*

and to regulate private involvement in education (2019).

76. *Statement by the GPE board chair on the June 2019 board meeting* (2019). Available at http://www.globalpartnership.org/news-and-media/news/statement-gpe-board-chair-june-2019-board-meeting.

77. World Health Organization, *Framework convention on tobacco control* (Geneva: World Health Organization, 2003); World Health Organization, *International code of marketing of breast-milk substitutes* (Geneva: World Health Organization, 1981).

78. A. Kembabazi and A. Mtsumi, *How can we assess the impact of the private sector in health care on the realisation of the right to health*? (Initiative for Social and Economic Rights). Available at http://www.gi-escr.org/publications/assessing-the-impact-of-the-private-sector-in-health-care-on-the-realisation-of-the-right-to-health.

79. General Assembly, Global Health and Foreign Policy, UN Doc. A/RES/67/81 (2013), paras. 3, 4.

80. See Committee on Economic, Social and Cultural Rights, General Comment No. 24, The Right to the Highest Attainable Standard of Health, UN Doc. E/C.12/2000/4 (2000).

81. K. Sumriddetchkajorn, K. Shimazaki, T. Ono, et. al., "Universal health coverage and primary care, Thailand," *Bulletin of the World Health Organization* 97 (2019), pp. 415–422.

82. Sustainable Development Goals Knowledge Platform, *Sustainable Development Goal 3: Progress and info 2019.* Available at http://sustainabledevelopment.un.org/sdg3.

83. Ibid.

84. UNAIDS, "The AIDS response and primary health care linkages and opportunities" (presentation at Global Conference on Primary Health Care, Astana, Kazakhstan, 2018). Available at http://www.who.int/docs/default-source/primary-health-care-conference/aids.pdf?sfvrsn=189b259b_2.

85. Transparency International, *Global corruption barometer Africa 2019: Citizens' views and experiences of corruption* (2019). Available at http://www.transparency.org/files/content/pages/2019_GCB_Africa.pdf.

86. UNAIDS, *Act to change laws that discriminate: Zero Discrimination Day, 1 March 2019* (2019). Available at http://www.unaids.org/sites/default/files/media_asset/2019_Zero-Discrimination_Brochure_en.pdf.

87. Ibid.

88. Office of the United Nations High Commissioner for Human Rights and World Health Organization, *The right to health: Fact sheet no. 31* (June 2008). Available at http://www.ohchr.org/Documents/Publications/Factsheet31.

89. International Monetary Fund, *Corporate taxation in the global economy* (2019). Available at http://www.imf.org/en/Publications/Policy-Papers/Issues/2019/03/08/Corporate-Taxation-in-the-Global-Economy-46650.

90. Center for Economic and Social Rights, *New human rights and fiscal justice initiative calls for global corporate tax reforms.* Available at http://www.cesr.org/new-human-rights-and-fiscal-justice-initiative-calls-global-corporate-tax-reforms.

91. Oxfam International, *5 Shocking facts about extreme global inequality and how to even it up.* Available at http://www.oxfam.org/en/5-shocking-facts-about-extreme-global-inequality-and-how-even-it.

92. Ibid.

93. J. D. Sachs, "Financing universal health coverage in low-income countries," in J. Kirton and I. Kickbusch (eds), *Health: A political choice* (2019).

94. UN Environment, *Nigerian Sustainable Finance Roadmap* (2018). Available at http://unepinquiry.org/wp-content/uploads/2018/11/Nigerian_Sustainable_Finance_Roadmap.pdf

95. World Health Organization, *Stronger collaboration, better health: Global action plan for healthy lives and well-being for all* (Geneva: World Health Organization, 2019).

96. *UHC2030.* Available at https://www.uhc2030.org.

97. Examples to build on include World Health Organization and Office of the United Nations High Commissioner for Human Rights, *Human rights, health and poverty reduction strategies* (Geneva: World Health Organization, 2008); Sida, World Health Organization, and Office of the United Nations High Commissioner for Human Rights, *Human rights and gender equality in health sector strategies: How to access coherence* (Geneva: World Health Organization, 2011).

98. Puras (see note 18).

99. S. Das, "Maternal health, human rights and the politics of state accountability: Lessons from the Millennium Development Goals and implications for the Sustainable Development Goals," *Journal of Human Rights* 17/5 (2018).

100. I. Saiz, "Human Rights in the 2030 Agenda: Putting justice and accountability at the core of sustainable development governance," in B. Adams, C. Alemany Billorou, R. Bissio, et al. (eds), *Spotlight on sustainable development 2019*: *Reshaping governance for sustainability* (2019).

PERSPECTIVE

Universal Health Coverage: Are We Losing Our Way on Women's and Children's Health?

FLAVIA BUSTREO AND CURTIS DOEBBLER

Our children are our future and one of the basic responsibilities is to care for them in the best and most compassionate manner possible.

—Nelson Mandela[1]

If women are denied a chance to develop their full human potential, including their potential to lead healthier and at least somewhat happier lives, is society as a whole really healthy?

—Dr. Margaret Chan[2]

This commentary argues that current efforts to achieve universal health coverage (UHC) risk losing some of the gains achieved on women's and children's health. Currently, there is a failure to prioritize women's and children's health in the vision for primary health care that is being promoted to achieve UHC. By failing to prioritize actions to protect the health of women and children, efforts to achieve primary health care—and thus UHC—are diluted. As a consequence, despite our good intentions, we move farther away from achieving health for all. This commentary encourages a rethinking and a move toward a diagonal approach to primary health care, with interventions for women's and children's health driving system improvements that will better achieve UHC.

Global commitments to prioritize women's and children's health

The prioritization of women's and children's health has both scientific and legal roots that indicate that it is essential for achieving the highest attainable health for a nation's population. One of the most notable expressions is in the Universal Declaration of Human Rights, where the right to health is defined as a comprehensive package of rights providing "a standard of living adequate for the health and well-being of [individuals] and [their families], including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond [their] control."[3] Since the 1978 Declaration

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of Alma-Ata, there has been broad agreement that primary health care is a prominent driver of health for all and UHC.[4]

Public health professionals have recognized for decades that prioritizing women's and children's health is an effective and efficacious means of improving public health generally. As Syed Masud Ahmed et al. conclude in their 2016 study of 10 countries that achieved Millennium Development Goals 4 and 5, interventions that achieved major reductions in under-five child mortality and maternal mortality between 1990 to 2015 contributed to "improvements in population-based coverage of high-impact interventions in health and other sectors."[5] This study merely confirmed what a 2010 study of 68 had found.[6]

The Sustainable Development Goals (SDGs) affirm the importance of women's and children's health by adopting indicators for the achievement of Goal 3 that are similar to those for the health-related Millennium Development Goals (4 and 5), which focused specifically on women's and children's health.[7] The first three indicators for SDG 3 relate to maternal mortality, births attended by skilled health personnel, and the preventable deaths of newborns and children under five.[8] Furthermore, indicator 3.8.1, specifically linked to the achievement of UHC, describes itself as "[c]overage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)."[9]

The legal imperative for prioritizing the health of women and children is found in numerous treaties and in customary international law expressing the right to health as an international legal obligation. Today, 170 of the 194 United Nations member states have ratified the International Covenant on Economic, Social and Cultural Rights, 53 states have ratified the African Charter on Human and Peoples' Rights, and 34 states have ratified the Revised European Social Charter.[10] Each of these instruments protects the right to health and calls for the special protection of women and children.[11]

Additionally, several legal instruments emphasize the legally binding nature of the obligation to prioritize women and children. The express protection of the right to health for women and children is found in articles 11(1)(f), 12, and 14(2)(b) of the Convention on the Elimination of All Forms of Discrimination against Women and in article 24 of the almost universally ratified Convention on the Rights of the Child.[12] The former instrument includes the ability of states to take affirmative action to redress past discrimination against women (art. 4), while the latter instrument demands that states give special protection to children (preamble).

Moreover, the repeated expression of *opinio juris* and practice of prioritizing women and children under international human rights law is also emphasized in the scientific context of primary health care and UHC. The scientific reiterations go back to at least the 1978 International Conference on Primary Health Care and its Alma-Ata Declaration, which includes maternal and child health care as part of the essential elements of primary health care. Most recently, paragraphs 28 (related to nutrition) and 29 (reiterating the general obligation of states to protect women and children in relation to access to health services) adopted by the United Nations General Assembly as the Political Declaration of the High-Level Meeting on Universal Health Coverage express the need to prioritize women and children.[13]

States' legally binding commitments are also reiterated in numerous aspirational instruments. For example, the aforementioned article 25 of the Universal Declaration of Human Rights provides that "[m]otherhood and childhood are entitled to special care and assistance." This aspiration is echoed in the American Declaration of the Rights and Duties of Man.[14] Both the 1924 and 1959 declarations on the rights of children call for their special protection.[15] These declarations express the *opinio juris* of the overwhelming majority of states in favor of their existing legal obligations as described above. Most recently, the Inter-Parliamentary Union, an international organization of parliaments made up of legislators from 173 states and with 11 associate members, adopted a resolution calling for efforts to

achieve UHC to be "consistent with international human rights standards" and to prioritize "essential services for women and children."[16]

There can be little doubt that these expressions of support both for the right to health and for the prioritization of women's and children's health are sufficient evidence of state practice and *opinio juris* to demonstrate that the right to health and the need to prioritize women and children have achieved the status of customary international law. As such, they can both be said to be universally legal binding norms and universally accepted as best practices in the field of public health. In other words, ensuring public health generally and prioritizing women and children in doing so are imperatives for all states.

What's wrong with our current approach to UHC?

Despite the abovementioned unequivocal expressions of the need to prioritize women and children, it is not happening in practice. Decades after we made solemn commitments to primary health care in Alma-Ata, there are signs that our commitment to provide primary health care for women and children is wavering. For example, at the recent commemoration of the Alma-Ata Declaration, the Declaration of Astana adopted at the 2018 Global Conference on Primary Health Care under the auspices of the World Health Organization (WHO) and the United Nations Children's Fund failed to prioritize women's and children's health, instead calling for a commitment to more general objectives related to UHC. Furthermore, the recent World Health Assembly resolution adopted by all WHO member states in preparation for the high-level meeting in New York on UHC does not include any reference to children and only a weak reference to women.[17]

While the goal of UHC is laudable, it is not clear that it is consistent with or an adequate practical expression of the right to health.[18] Undoubtedly, the failure to lay its foundation in a rights-based approach—where primary health care for women and children is central—undermines the very basis on which UHC is predicated. Such an approach to UHC might even be harmful to the health of families because it allows manipulation by a government seeking to control rather than empower its population. It is a step back toward the outdated practice of imposing health care from above, or, even perhaps more harmfully, of providing health care only when it is financially profitable. In fact, there is significant evidence that investing in women's and children's health is the more cost-effective investment that states can make for achieving universal health coverage.[19]

This is an argument not for a vertical approach but for a diagonal one, which Julio Frenk has described as a "strategy in which we use explicit intervention priorities to drive the required improvements into the health systems" and health services.[20] It has been convincingly argued that the prioritization of interventions to protect women's and children's health has produced the most substantial public health benefits for the people in countries where such an approach has been taken.[21]

The current approach to UHC also fails to adequately embrace participation and accountability, two elements that are central to a rights-based approach to health. This is contrary to the desire expressed by governments and nongovernmental actors to make participation more meaningful and to provide for accountability mechanisms. Both the Alma-Ata Declaration (para. VI) and the Astana Declaration (para. IV) call for greater participation. The latter declaration also embraces the idea that greater participation contributes to accountability (para. IV).

The need for accountability, which emerged more recently, is confirmed by efforts to create human rights mechanisms to allow individuals to complain about government failure to protect the right to health. In Africa, Europe, and the Americas, for example, most countries have agreed to allow individuals to challenge their governments when they fail to ensure the right to health. In addition, the United Nations General Assembly's 2017 resolution "Global Health and Foreign Policy: Addressing the Health of the Most Vulnerable for an Inclusive Society," adopted by 152 votes, states that appropriate participation must be safeguarded by

strengthened accountability.[22] Lastly, the first United Nations Special Rapporteur on the right to the highest attainable standard of health, Paul Hunt, has unequivocally stated that "the right to health … demands accountability."[23]

Prioritizing women's and children's health is an imperative, not a political choice

States have expressed that prioritizing women's and children's health is an imperative, not a political choice. This difference is important. When conceptualized as a political choice, health priorities are merely trade cards in a political game of self-interests, where the interests of the rich and powerful often trump those of all others. When conceptualized as an imperative, they are non-negotiable goals that governments must strive to achieve.[24] As an imperative, prioritizing the health of women and children must be the basis of primary health care and therefore essential to the effective implementation of UHC. There are numerous consequences of this recognition.

As the aforementioned legal obligations indicate, achieving the right to health and prioritizing women and children while doing so imposes international legal responsibilities on states. These legal obligations require that states ensure interventions that protect public health and provide special protections for women and children. If states do not meet this responsibility, they may be held accountable by the people under their jurisdiction in both domestic and international forums. Already, countries such as South Africa and India have imposed significant obligations on states in relation to the right to health and specifically in relation to women's and children's health.[25] While such accountability mechanisms are still underdeveloped, it is rational to believe that they will continue to develop.

Setting the health of women and children as a public health priority also makes economic sense. Investing in prioritizing interventions to promote and protect women's and children's health is the "best buy" a state can make in its public health.[26] This is a significant concern for states trying to stretch limited resources to fast-growing populations.

Protecting women and children is also logical because states' health indicators virtually always begins with maternal, infant, and child mortality. The truth of this statement was demonstrated in 2015, when states adopted these indicators as the primary point of reference for SDG 3.[27] Interventions that show progress in these indicators not only improve public health but also do so in measurable and apparent ways. Such observable advances in public health are both politically valuable and useful for comparative measurement, which, in turn, as stated by former WHO director-general Margaret Chan, means that "[w]hat gets measured get done."[28]

Achieving the prioritization of women's and children's health as an imperative is also enhanced by cooperation between the Office of the United Nations High Commissioner for Human Rights (OHCHR) and WHO. Professor Gillian MacNaughton has chronicled this cooperation.[29] She notes that in 2015, the OHCHR collaborated with WHO and the United Nations Population Fund to produce technical guidelines for policy makers seeking to implement a human rights-based approach to maternal and child health.[30]

A year later, the OHCHR and WHO collaborated to establish the High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents and on the development and adoption of the United Nations Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health for 2016–2030.[31] The high-level working group recommended that WHO and OHCHR collaborate even more closely on health and human rights.[32]

In November 2017, WHO and the OHCHR agreed to the WHO-OHCHR Framework of Cooperation committing each entity to cooperate on the right to health in general terms. The agreement, which is not in the public domain, does not call for measurable results or provide for accountability. Nevertheless, it evidences the general willingness of these important actors to continue to work toward fulfillment of the right to health. If implemented in good faith—in a participatory manner with an effective accountability mechanism—this agreement

could be an important step toward ensuring the prioritization of women and children in countries and in global UHC strategies.

The prioritization of women's and children's and health makes good sense both legally and scientifically. States have expressed the will to do this in United Nations forums. It is hoped that WHO's laudable effort to achieve UHC will keep pace with these expressions of commitment to women's and children's health. These are two of the most important groups of people whose health, when adequately prioritized, reflects most significantly on the health of us all. As one of the leading proponents of UHC has noted, putting "women and children first [is] an appropriate first step towards universal coverage."[33]

References

1. N. R. Mandela, *Address by Nelson Mandela at opening of Walter Sisulu Paediatric Cardiac Centre for Africa, Johannesburg* (November 7, 2003). Available at http://www.mandela.gov.za/mandela_speeches/2003/031107_cardiac.htm.

2. Quoted in "WHO: Women's health an 'urgent priority'," *CNN* (November 11, 2009). Available at http://www.cnn.com/2009/HEALTH/11/11/women.health/index.html.

3. Universal Declaration of Human Rights, G.A. Res. 217A (III) (1948).

4. International Conference on Primary Health Care: Declaration of Alma-Ata, Alma-Ata, September 6–12, 1978.

5. S. M. Ahmed, L. B. Rawal, S. A. Chowdhury, et al., "Cross-country analysis of strategies for achieving progress towards global goals for women's and children's health," *Bulletin of the World Health Organization* 94/5 (2016), p. 352.

6. See generally Z. A. Bhutta, M. Chopra, H. Axelson, et al., "Countdown to 2015: Decade report (2000–10); Taking stock of maternal, newborn, and child survival," *Lancet* 375/9730 (2010), pp. 2032–2044.

7. UN General Assembly, Res. 70/1, UN Doc. A/RES/70/1 (2015).

8. UN General Assembly, Res. 71/313, UN Doc. A/RES/71/313 (2017), p. 6.

9. Ibid., p. 7.

10. International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI) (1966); African Charter on Human and Peoples' Rights, OAU Doc. No. CAB/LEG/67/3 rev. 5 (1981); Revised European Social Charter, ETS No. 163 (1996).

11. See International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI) (1966), art. 12; African Charter on Human and Peoples' Rights, OAU Doc. No. CAB/LEG/67/3 rev. 5 (1981), arts. 16, 18; Revised European Social Charter, ETS No. 163 (1996), I(7), I(8), I(11), II(7), II(8).

12. Convention on the Elimination of All Forms of Discrimination against Women, G.A. Res. 34/180 (1979); Convention on the Rights of the Child, G.A. Res. 44/25 (1989).

13. UN General Assembly, "Universal health coverage: Moving together to build healthier world" (adopted September 23, 2019, at the High-Level Meeting on Universal Health Coverage).

14. American Declaration of the Rights and Duties of Man, O.A.S. Res. XXX (1948), art. VII.

15. See generally Geneva Declaration of the Rights of the Child (1924); UN General Assembly, Res. 1386 (XIV) (1959), principle 2.

16. Inter-Parliamentary Union, "Achieving universal health coverage by 2030: The role of parliaments in ensuring the right to health" (adopted October 17, 2019).

17. World Health Assembly, Res. WHA72.4 (2019), para. 1(6).

18. See G. Ooms, L. A. Latif, A. Waris, et al., "Is universal health coverage the practical expression of the right to health care?" *BMC International Health and Human Rights* 14 (2014).

19. See Ahmed et al. (see note 5); Bhutta et al. (see note 6).

20. J. Frenk, "Bridging the divide: Comprehensive reform to improve Health in Mexico" (lecture for WHO Commission on Social Determinants of Health, Nairobi, Kenya, June 29, 2006). Available at http://www.who.int/social_determinants/resources/frenk.pdf.

21. J. Sepúlveda, F. Bustreo, R. Tapia, et al., "Improvement of child survival in Mexico: The diagonal approach," *Lancet* 368/9551 (2006), pp. 2017–2027.

22. UN General Assembly, Res. 72/139, UN Doc. A/RES/72/139 (2018), para. 11.

23. P. Hunt, "The human right to the highest attainable standard of health: New opportunities and challenges," *Transactions of the Royal Society of Tropical Medicine and Hygiene* 100/7 (2006), p. 604.

24. See F. Bustreo and C. F. J. Doebbler, "Health and foreign policy: The human rights imperative," *Health and Human Rights Journal* 12/1 (2010), pp. 47–59.

25. See, for example, M. Heywood, "Preventing mother-to-child HIV transmission in South Africa: Background, strategies and outcomes of the Treatment Action Campaign's case against the Minister of Health," *South African Journal on Human Rights* 19/2 (2003), pp. 278–315; Center for Reproductive Rights, *Maternal mortality in India: Using international and constitutional law to promote accountability and change* (New York: Center for Reproductive Rights, 2011).

26. See K. Stenberg, H. Axelson, P. Sheehan, et al., "Advancing social and economic development by investing in women's and children's health: A new global investment

framework," *Lancet* 383/9925 (2014), pp. 1333–1354.

27. See UN General Assembly, Res. 70/1, UN Doc. A/RES/70/1 (2015).

28. M. Chan, "WHO Director-General's speech at the summit on measurement and accountability for results in health" (Measurement and Accountability for Results in Health Summit, Washington, DC, United States, June 9, 2015).

29. G. MacNaughton, "Promotion and protection of the right to health by the Office of the UN High Commissioner for Human Rights," *Global Health Governance* 12/1 (2018), pp. 47–61.

30. Ibid., p. 54. See also United Nations, Annual Report of the United Nations High Commissioner for Human Rights, UN Doc. A/HRC/31/3 (2015), para. 75.

31. MacNaughton (see note 29), p. 54. See also High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents, "Leading the realization of human rights to health and through health" (2017).

32. High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents (see note 31), p. 55.

33. R. Yates, "Women and children first: An appropriate first step towards universal coverage," *Bulletin of the World Health Organization* 88 (2010), pp. 474–475.

UHC2030's Contributions to Global Health Governance that Advance the Right to Health Care: A Preliminary Assessment

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Abstract

The September 2019 United Nations High Level Meeting on Universal Health Coverage (UHC) aims to mobilize top-level political support for action on UHC to advance the health Sustainable Development Goal (SDG). A driving force behind this meeting is the "UHC Movement," led by UHC2030, which focuses on coordinating and amplifying efforts by WHO, the World Bank, civil society, and the private sector to strengthen health systems and achieve UHC. In line with Horton and Das, this paper contends that while the argument about UHC is won, it is crucially important to focus on "how" UHC will be delivered, and specifically, whether ongoing efforts to advance UHC align with efforts to realize the right to health. This paper offers a preliminary assessment of how UHC2030's contributions to global health governance advance, or not, the right to health care. It builds on a 2014 G04Health study which identified key normative overlap and gaps in UHC and right to health care principles. Given the importance of civil society participation in advancing health rights, this analysis is complemented by an examination of how UHC2030 might amplify ongoing efforts to advance the right to health care in two UHC2030 partner countries, Kenya and Uganda.

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Introduction

As jockeying for political priority in the Sustainable Development Goals (SDGs) era escalates, attention to the health goal (SDG 3) and the right to health at the United Nations level is largely focused on target 3.8, universal health coverage (UHC).[1] The World Health Organization (WHO) claims that "UHC is, by definition, a practical expression of the concern for health equity and the right to health."[2] In line with Horton and Das, this paper contends that while the argument about UHC has been won it remains crucially important to focus on "how" UHC will be delivered, specifically whether ongoing efforts to advance UHC align with efforts to realize the right to health, thus advancing rights based global health governance.[3] The relationship between the realization of the right to health—or even the acknowledgment of the existence and importance of the right to health—and the global fight against HIV/AIDS is widely acknowledged. Civil society played a crucial role in advancing the right to health for people living with HIV.[4] Therefore, if one posits that UHC can play a similar role in the realization of the right to health, one should not only look at the roles of WHO and the World Bank, key global health governance institutions, but also at how these organizations interact with civil society. One of the driving forces behind the September 2019 United Nations High-Level Meeting on Universal Health Coverage ("UN UHC meeting") was the "UHC Movement," led by UHC2030, a multi-stakeholder partnership which focuses on coordinating and amplifying efforts by WHO, the World Bank, national governments, civil society, and the private sector to strengthen health systems and achieve UHC.[5] As UHC2030 acts as a link between national governments, civil society, and key global health actors, like the World Bank and WHO, the extent to which it advances an approach to UHC that aligns with health rights is important for advancing rights based global health governance. This paper offers a preliminary assessment of how UHC2030's contributions to global health governance advance, or not, the right to health care in the SDG era.[6]

In April 2019, UHC2030 launched its six key asks for the UN UHC meeting. The first asks governments to "Commit to achieve UHC for healthy lives and wellbeing for all at all stages, as a social contract."[7] This language in this document echoes that used by the Goals and Governance for Global Health consortium (G04Health), whose research analyzed the development of the health SDG and made the case for a new global social contract that advanced the right to health comprising two key components; UHC anchored in the right to health and a healthy natural and social environment.

This article builds on a 2014 G04Health study which identified key normative overlap and gaps in the principles embedded in the right to health care and UHC.[8] That study focused on the right to health care—narrower than the right to health—because UHC, notwithstanding the inclusion of 'preventive' and 'promotive' efforts in many of its definition, actually focuses on access to health care. Therefore, it would be somewhat unfair to expect UHC to drive the realization of the broader right to health. This article explores how UHC2030's approach to advancing UHC addresses, or not, these gaps to better understand how its normative underpinnings align with those of the right to health care, thus allowing us to assess whether it contributes to advancing rights-based global health governance. Given the importance of civil society participation in advancing the right to health care, this analysis is complemented by a brief examination of how UHC2030 might amplify ongoing efforts to advance the right to health in two UHC2030 partner countries, Kenya and Uganda. These countries were selected because key national civil society actors have recently published extensive studies on efforts to realize the right to health in each.[9]

Section one reviews the shift from the Millennium Development Goals (MDGs) to the SDG era, examining how this shift suggests a more comprehensive approach to advancing health rights. Section two draws on the 2014 G04Health analysis to summarize the overlap and gaps between UHC and the principles underpinning the right

to health care. Section three introduces UHC2030, an increasingly influential global health actor, and examines key UHC2030 documents to assess how its goals and approach to advancing UHC address gaps related to the right to health. Section four turns to Kenya and Uganda to illustrate how UHC2030 efforts influence national and local level actions to close these gaps by focusing on community participation, and how this can amplify ongoing efforts to advance the right to health care.

Shifting goals and governance: from the MDGs to the SDGs

The impact of the MDGs on advancing global health goals by focusing on components of the right to health was impressive, but progress was uneven. The shift in global burden of disease from communicable to non-communicable was a factor in mobilizing support for a broader post-MDG health agenda.[10] The impact of uneven global attention and progress was evidenced by the large upswing in funding to communicable diseases in contrast to smaller increases to non-communicable diseases (see Table 1.[11]) While efforts to advance on broader areas like health systems strengthening were funded, other vital areas, such as primary health care and the importance of addressing the interconnected nature of rights, were not prioritized for funding or institution-building.

The global consultations on the MDGs' successors saw a shift in the approach to global health, with countries embracing a universal goal: one for all countries, within a global framework that recognized the interconnected nature of rights.[12] The ensuing negotiations presented countries with an opportunity to recommit to their legal obligations under the International Covenant on Economic, Social and Cultural Rights (ICESCR), including Article 12, the right to the highest attainable standard of physical and mental health (right to health).[13] As Brolan et al.'s research documents, the combination of political misgivings and concerns about the practical translation of the right to health into measurable targets contributed to it lacking sufficient political traction to become the post-2015 health goal.[14]

In September 2015, the United Nations General Assembly (UNGA) agreed on the post-2015 development agenda, with a broadly framed health goal, SDG 3, "Ensure healthy lives and promote well-being for all at all ages," and UHC as a target (3.8) committing states to "Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all."[15]

Although the right to health did not emerge as the post-2015 health goal, many global health and rights scholars welcomed the new health goal, focusing on the potential of UHC to deliver progress on the right to health.[16] Some, including many Go4Health members, urged caution, noting the importance of anchoring UHC in the right to health to ensure that the process of delivering UHC to diverse communities is aligned with rights-based approaches.[17] Such an approach addresses the tension between the aim of an internationally agreed goal, UHC, with the expectation that health efforts will be responsive to the specific needs identified by a given community. The importance of anchoring UHC in the right to health is that while it allows progress adapted to national circumstances it requires a human rights-based ac-

TABLE 1. Development assistance for health (DAH) by health focus area, 1990-2017

Health focus area	Total in US dollars (billions)
Maternal, newborn, and child health	173.8
HIV and AIDS	141
Health systems strengthening/SWAPs	81.3
Malaria, TB, and other infectious diseases	69.3
Non-communicable diseases	9.6

countability framework, community participation in priority setting, and an overarching commitment to non-discrimination.

UHC versus UHC anchored in the right to health

This section draws on the 2014 Go4Health analysis summarizing the overlap between the normative elements of UHC and the obligations arising under the right to health care. It highlights the areas that UHC2030 needs to address to ensure that the UHC priorities it advocates for are consistent with advancing the right to health care, thus contributing to rights-based global health governance.

UHC: A powerful concept with no single definition

Despite numerous UN resolutions, widespread commitments to and praise for UHC, there is no universally agreed definition; as Go4Health concluded, "there is no single authoritative formulation of UHC."[18] The flexibility of the concept is an advantage, allowing it to garner support from diverse actors, but it also carries the risk that more politically and financially powerful voices, who may not support a rights-based agenda, will exercise greater influence over the priorities and process of advancing UHC.

The right to health in international law: Key principles

State obligations to safeguard and realize health-related rights are enshrined in WHO's Constitution and in Article 12 of ICESCR. These obligations are further clarified in General Comment 14, which affirms that the right to health is a "fundamental human right indispensable for the exercise of other human rights," and that "every human is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity."[19]

The right to health is not a right to be healthy but the universal right to accessible, affordable, and acceptable health care and the underlying determinants of health. It imposes both national and international legal obligations on States parties requiring that health care is both comprehensive and progressive in accordance with seven principles. These include, first, the principle of progressive realization, which requires that each state employs the maximum of its available resources to advance the right for all. Second, the principle of non-discrimination requires that the availability, accessibility, and quality of health care is universal and sufficiently adaptable to suit all. Third, the public health principle of cost-effectiveness, which needs to be read in conjunction with non-discrimination, and requires that states make choices about the health care provided by allocating health resources so that they benefit a larger part of the population (that is, primary and preventive health care). Fourth, participatory decision-making requires that states develop a national public health strategy and plan of action through an inclusive, participatory, transparent process. General Comment 14 spells out obligations regarding non-state actors including the obligation to ensure that "coordinated efforts for the realization of the right to health are maintained to enhance the interaction among all the actors concerned, including the various components of civil society."[20] Fifth, the process for developing the national strategy and plan of action requires that special attention be paid to the needs of those made vulnerable or marginalized. This principle ensures that if a particular health condition disproportionately affects a vulnerable or marginalized segment of the population it may be incumbent on the state to include this condition in its health care strategy, even if it fails the cost-effectiveness test. Sixth, the minimum core obligations established in General Comment 14 apply to all states, high or low income, and include providing essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs and ensuring equitable distribution of all health facilities, goods, and services. The seventh principle is shared responsibility, enshrined in Article 2(1) of ICESCR, according to which States parties commit to "take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization

of the rights recognized in the present Covenant by all appropriate means...".[21] This requires that states in a position to assist are legally obliged to engage in international assistance and cooperation that prioritizes advancing, at a minimum, the core obligations under the right to health.[22] This reflects the understanding that development assistance for health is an international human rights obligation, not a matter of charity.[23]

Overlap between UHC and the right to health care

Drawing on the key international legal documents and authoritative opinions outlined above, Go-4Health members compared the key normative elements of the right to health care with those of UHC and concluded that there was overlap on the key right to health principles of progressive realization, non-discrimination, and cost effectiveness. In assessing how UHC tracks with the right to health principles of participatory decision making and prioritization of vulnerable and marginalized groups, there was less overlap. Specifically, the 2012 UNGA Resolution is imprecise regarding how to ensure the relevant decision-making processes will be participatory or that these processes will include and prioritize the needs of vulnerable or marginalized groups.[24]

UHC and the right to health care diverge most with respect to the right to health care principles of core obligations and shared responsibility. In terms of minimum core obligations, the UNGA resolutions and WHO documents are ambiguous as to what framework should guide country decision making when public funding shortfalls require decisions as to what health care or medicines are to be included in the national UHC plan. The 2012 WHO Discussion Paper notes that UHC implies that people "have access to all the services they need." This definition is too vague. Even in a high income country like Canada, with a long UHC history, the absence of universal coverage for necessary medicines continues to create barriers to access and is arguably a violation of the country's minimum core obligations tied to the right to health.[25]

The commitment to the international legal obligation of shared responsibility to realize the right to health care is largely absent from UHC documents. The preamble of the 2005 UNGA Resolution includes a reference to international assistance and the 2012 UNGA Resolution makes a vague and non-committal reference to "universal health coverage on the basis of solidarity at national and international levels." G04Health analysis clarifies that a definition of UHC that does not include a commitment to shared responsibility means that "in low and lower middle income countries, UHC could mean access to a very cheap and incomplete package, not including antiretroviral AIDS treatment, for example."[26] The risk of such an approach to UHC is that it may deliver less for People Living With HIV and AIDS in those countries than under the MDGs.

UHC2030: Origins, goals, and efforts to advance the right to health

Coordinating global health efforts: evolving from the MDG to the SDG era

In an effort to tackle problems related to diverse, uncoordinated approaches to advancing human rights and development in the MDG era, countries agreed upon five aid effectiveness initiatives between 2005 and 2011. The first was the 2005 Paris Declaration

TABLE 2. Comparing right to health care principles to UHC commitments

Right to health care principles	UHC commitments
Progressive realization	Yes
Non-discrimination	Yes
Cost-effectiveness	Yes
Participatory decision making	Not so clear
Prioritizing vulnerable and marginalized groups	Not so clear
Minimum core obligations	Unrealistically broad (all health care needed)
Shared responsibility	Absent

on Aid Effectiveness (Paris Declaration), which prioritized country ownership and accountability, clearer targets and indicators of success, a commitment to harmonization among partners, alignment with nationally prepared country strategies, and mutual accountability for measurable outcomes.[27]

The 2007 International Health Partnership (IHP+) aimed to put the principles of the Paris Declaration into action by improving DAH coordination and effectiveness through bringing together diverse actors committed to advancing on the health MDGs in low income countries, including countries in a position to assist, countries needing assistance, civil society organizations, and multilateral organizations.[28] It launched a global compact aimed at building confidence among these stakeholders by encouraging broad support across all partners for a single national health strategy, a single monitoring and evaluation framework, and a strong emphasis on mutual partner accountability.[29]

IHP+ members, including WHO and the World Bank, championed UHC as the SDG health goal for advancing greater accountability, alignment, participation, and effectiveness. Following the SDG launch, the IHP+ transformed into the International Health Partnership for Universal Health Coverage 2030 (UHC2030), a new global health governance actor, aiming to

- improve coordination of health systems strengthening (HSS),
- strengthen and coordinate multi-stakeholder dialogue and adhere to IHP+ principles,
- facilitate accountability for progress toward HSS for UHC, and
- build political momentum for a shared vision and advocate for sufficient, appropriate, and well-coordinated resource allocation to HSS.[30]

Unpacking the UHC2030 approach

The UHC2030 Global Compact (Global Compact) was launched in 2017 and requires UHC2030 partners to advance the SDG objective of leaving no one behind, by, *inter alia*, committing to equity, non-discrimination, and a rights-based approach, and secondly, assuring transparency and accountability for results.[31] As Ogbuoji and Yamey observe, the 2015 Addis Ababa Action Agenda and the Global Compact take the aid effectiveness agenda into the SDG era.[32]

In April 2019, UHC 2030 issued its Six Asks for the UN UHC Meeting (see Table 4), which echo the language of the principles underpinning the right to health (as explored in section 2).[33]

To dig deeper into the Six Asks, we examine two key UHC2030 documents, the Global Compact and the Joint Vision.[34] Given the importance of civil society participation in advancing the right to health care, we also examine the contributions of the Civil Society Engagement Mechanism for UHC2030 (CSEM), entitled "Civil society per-

Table 3. From IHP+/MDG era to UHC2030/SDG era

	IHP+	UHC2030 Global Compact
Objective	The health MDGs	The health SDG (focus on health systems strengthening and UHC)
Scope	Low- and middle-income countries	All countries (universal)
Goals	1. Ensuring DAH is: effective aligned coordinated 2. Accountability	1. Leave no one behind: a commitment to equity, non-discrimination, and a rights-based approach 2. Transparency and accountability for results 3. Evidence-based national health strategies and leadership 4. Making health systems everybody's business, through engagement of citizens, communities, civil society, and private sector 5. International cooperation based on mutual learning, progress in achieving and sustaining UHC, and development effectiveness principles.
Signatories and partners	Primarily partner countries and bilateral donors, with multilaterals, philanthropic foundations. Civil society is represented on the Steering Committee but cannot sign the compact.	Open for signature by all countries, governments, parliaments, multilaterals, civil society, philanthropies, and the private sector.

spective on how UHC can be reached by 2030" (CESM-P).[35] The objective is to unpack how the commitments and approaches to advancing UHC in these documents address, or not, the key normative gaps outline in section 2, specifically the right to health principles of participatory decision making, prioritization of vulnerable and marginalized groups, minimum core obligations, and shared responsibility. This allows us to assess the extent to which UHC2030 advances, or not, global health governance that advances health rights.

Participatory decision making and prioritizing vulnerable and marginalized groups

The right to health care requires that a national health strategy and plan of action (a core obligation) is formulated through an inclusive, participatory decision making process that prioritizes the participation and needs of vulnerable and marginalized groups.

The Joint Vision document highlights that a human rights-based approach to promoting UHC must address inequalities and exclusion, include inclusive health policies and programs, and mobilize civil society (page 11). It emphasizes the importance of systematically anchoring civil society participation in health systems-strengthening activities to enable people-centered health services (page 22). Additionally, it references the importance of multi-stakeholder dialogue with communities and civil society, "including in particular organizations representing disease-affected or marginalized and vulnerable groups, as well as the private sector for developing implementing and monitoring national health strategies." (page 22) Thus the norms advanced in the Joint Vision do not fully reflect the human rights principle of prioritizing vulnerable and marginalized groups because, as noted above, vulnerable and marginalized groups are listed as one of several stakeholders to be consulted, which is not the same as prioritization.

The Joint Vision states that "progressive pathways towards universality may require policies and strategies addressing trade-offs between coverage and equity to ensure that people who have not access to affordable quality services gain at least as much as those who are better off at every step of the way toward universal coverage." (page 10) Progressive pathways towards universality is not the same as committing to policies and programs that deliver the "progressive universalism" referenced by Horton and Das, which aligns with the right to health principle of prioritizing vulnerable and marginalized groups.

The Global Compact reiterates the principle that "progressive pathways towards universality that endeavor to first reach the most vulnerable and marginalized population groups are key to ensure no one is left behind." However, Global Compact signatories do not commit to put in place an inclusive participatory process to develop a national strategy that reflects the essential health needs of the vulnerable and marginalized. They do commit to "evidence-based national health strategies and leadership, with government stewardship to ensure availability, accessibility, acceptability and quality of service delivery," and making "health systems everybody's business" through engaging with citizens, communities, civil society, and the private sector.

An evidence-based national health strategy is not the same as a national health strategy that has been developed in partnership with diverse communities, including those that are marginalized. Further, government stewardship does not ensure that the needs of vulnerable and marginalized

TABLE 4. The Six Asks

Ensure political leadership beyond health	Commit to achieve UHC for healthy lives and well-being for all at all stages, as a social contract
Leave no one behind	Pursue equity in access to quality health services with financial protection
Regulate and legislate	Create a strong, enabling regulatory and legal environment responsive to people's needs
Uphold high-quality health	Uphold quality primary health care (PHC) as the backbone of UHC and an entity that creates trust in public institutions
Invest more, invest better	Sustain public financing and harmonize health investments
Move together	Establish multi-stakeholder mechanisms for engaging the whole of society for a healthier world

populations will be prioritized. In some countries, the relationship of minority communities with the government may be tainted by the legacy of oppression, and/or the government may be the source of their exclusion and vulnerability, as is the case with many migrant communities the world over. The commitment to "engagement of citizens, communities, civil society and private sector" is weaker than the requirements of the right to health. In the absence of a commitment to meaningful, inclusive broad-based consultation processes and input into designing a national health strategy, the priorities in the national health strategy risk reflecting and amplifying entrenched asymmetries of power. The commitment to making health systems everybody's business is not the same as committing to the right to health care principle of a national public health strategy and plan of action that is "devised, and periodically reviewed, on the basis of a participatory and transparent process" as required under General Comment 14.

In line with the Global Compact and Joint Vision, the CSEM-P insists on the importance of accountability and emphasizes that because health is a human right, policies to advance UHC must ensure that no one is left behind. It goes further in its commitment to progressive universalism, stating "civil society groups believe that UHC policies need to ensure that populations most in need are targeted first, with appropriate and inclusive services." It also argues for multi-level (local to global) advocacy and engagement with marginalized groups to ensure that "future national health plans and policies assess which populations are currently left behind and have insufficient access to health services and explicitly target those populations most in need." The CSEM-P therefore calls for civil society across all sectors (not just health- or UHC-focused) to engage in ensuring that national health plans are clearly focused on the multiple barriers that obstruct access to health care.

Significantly, the CSEM-P highlights that the importance of community involvement goes beyond informing health decision making, but that it should also contribute towards accountability and transparency across all the stakeholders. Such involvement should see civil society engaged in decision making processes across the different levels, including national and district, "to monitor progress against outcomes towards UHC including the health budget and ensure adherence to commitments."[36] The CSEM-P also raises the mechanism of social-led accountability, advocating for its strengthening to contribute towards the integrity of the health system and to deal with the problem of corruption, which drains resources.

The CSEM-P document is the only UHC2030 document that reflects the transformation in thinking required to implement a rights-based approach to advancing the right to health care, as it recognizes the depth and breadth of engagement needed. The commitments and processes outlined in the Joint Vision, Global Compact, and Six Asks do not yet make this transformative leap but are steps on the path.

Minimum core obligations

Like UHC, the concept of minimum core obligations has its own conceptual and definitional challenges.[37] Clearly it is not within UHC2030's mandate to engage in the discussion on the scope of the minimum core obligations under the right to health. However, to advance the right to health care, UHC2030's approach to advancing UHC should advocate prioritizing the minimum core obligations under the right to health. The Six Asks is silent on this. The Joint Vision highlights the importance of a rights-based approach, noting that "a human rights-based approach provides not only a framework for accountability but also for development of inclusive health policies and programs, and for mobilizing civil society to achieve the right to health" (page 11), and the Global Compact commits signatories to a rights-based approach. The CSEM-P emphasizes the importance of increasing budgets for health needs through mandatory and fair pooling mechanisms and removing financial barriers to accessing essential care packages. Accordingly, the CSEM-P argues that "primary health care linked to essential health services packages should be given priority." Countries need to define their essential care packages at the national level,

and these should be accompanied with "a concrete plan to ensure the removal of direct cash payments as an urgent measure." The key questions to address here are: how will UHC2030 engage with the issue of what health care services and medicines are included? *Who* is covered?[38] We shall use the example of HIV and AIDS to unpack this challenge.

Many HIV and AIDS advocacy and empowerment groups are concerned with the extent to which HIV and AIDS programming and services will be integrated into national UHC benefits packages.[39] Two key interrelated issues impact on how this question is answered. The first is who decides and the second is how they decide, which brings us back to the interrelated human rights principles of participatory decision making and prioritization of vulnerable and marginalized groups. The second issue, addressed below, centers around shared responsibility and the extent and reliability of global commitments to fund UHC that includes access to treatment for HIV and AIDS.

National level determinations of what falls into the category of UHC risk undermining the progress on access to HIV and AIDS services and medicines. If national health plans to advance UHC include and prioritize the concerns of vulnerable and marginalized groups, then affordability and access to HIV and AIDS-related services should continue to be prioritized.

Shared responsibility

G04Health research identified the human rights obligation of shared responsibility for advancing the right to health as a lacuna in UHC definitions and programming. Clearly, the importance of DAH for advancing UHC in many countries will continue to decrease throughout the SDG era. Yet, for the foreseeable future, many low-income countries will need to rely on DAH to fund efforts to advance on UHC. A July 2019 World Bank study argues that closing the substantial UHC financing gap in 54 low- and lower middle-income countries will require a strong mix of domestic and international investment, including a sizable increase in DAH.[40] In addition, many countries will be facing the challenge of increased reliance on domestic financing for their entire health budget as they "transition" to middle-income status and lose access to DAH and international funding for their HIV and AIDS response.[41] The human rights obligation of shared responsibility for advancing the right to health is not acknowledged in either the Six Asks or the three UHC2030 documents.

With regards to domestic financing, the UHC2030 Compact and the Joint Venture take their lead from the Addis Ababa Agenda for Action, which focuses on the importance of mobilizing domestic resources and increasing public financing. These commitments are in line with domestic component of the right to health. The CSEM-P highlights that "civil society strongly supports progressive domestic resource mobilization to ensure progress towards UHC and Health System Strengthening " The CSEM-P requires governments to "progressively increase their investment in health and move towards the proposal of allocating at least 5% of annual GDP as government health care expenditure." This suggests a shift away from the Abuja approach that required governments to commit 15% of the national budgets towards health. This is a significant change that deserves monitoring, as many African countries have been pushed to focus on the Abuja target, which is not yet achieved by many.

With respect to the international component of shared responsibility, the Six Asks and the Joint Vision (page 17) recognize that DAH is complementary to domestic resources, noting the importance of alignment and effectiveness. This is in contrast to the weak language in the UHC2030 Compact, where partners simply reiterate their "commitment to the principles and behaviours of effective development cooperation." No attention is paid to the obligation of engaging in technical assistance and cooperation as required under the right to health. The documents are also silent on the Overseas Development Assistance commitment of 0.7% of GNI and the consequences of the flat-lining of the volume of DAH in combination with the ability (or inability) of countries to mobilize more domestic resources.[42] As Haakenstad et al note, "a large gap

exists between available financing and the funding needed to achieve global HIV/AIDS goals, and sustained and coordinated effort across international and domestic development partners is required to end AIDS by 2030."[43]

The Six Asks move even further from a rights-based approach, stating, "Countries need to adapt to transition from external funding that aim to increase effective coverage of priority interventions toward achieving and sustaining UHC." Further, it advocates for a global public goods approach as opposed to a rights-based approach when it states that countries should "Invest in global and regional public goods including universal access to essential medicines, vaccines, technology and emergency preparedness." If countries use a global public goods framework to establish health funding priorities, then the funding of health programs and policies will reflect the interests of wealthy countries, rather than those of countries requiring assistance. This is at odds with the human rights-based approach.[44]

The CSEM-P also remains stuck in the logic of donors and aid, as opposed to the recognition of shared responsibility as a human rights obligation. It states: "Donor governments, however, also have a crucial role to play in providing their fair share to achieve SDG 3.8 fully aligned with countries' plans, in line with the aid effectiveness principles and the WHO recommendation of funding levels not below 0.1% of GNI." This language does not reflect a right to health understanding of the legally binding obligations of countries in a position to assist.

How UHC2030 can amplify Ugandan and Kenyan UHC efforts

This assessment now turns to examining how the UHC2030 commitments and approach to advancing UHC can complement efforts to advance the right to health in Uganda and Kenya. Both are UHC2030 partner countries and States parties to numerous international human rights treaties, including ICESCR. We draw on two recent civil society studies on health rights, which focused on the challenges related to advancing on the principles of participatory decision making, prioritization of vulnerable and marginalized groups, and the minimum core, and supplement these with developments in 2019.[45]

Kenya

In Kenya, access to health care is both a constitutional imperative and an administrative policy; this offers a unique opportunity to interrogate how the current administration has interpreted its constitutional obligation in light of its UHC2030 engagement. The right to health is enshrined in the Kenyan Constitution, which states: "Every person has the right to the highest attainable standard of health, which includes the right to healthcare services, including reproductive health."[46] To achieve this right, the current government adopted UHC as one of four priority agendas, aiming for all persons in Kenya to be able to use the essential services they need for their health and wellbeing through a single unified benefit package, without significant financial risk, by 2022.[47] Through UHC, the state has committed to subsidize 100% of costs on essential services and reduce medical out of pocket expenses by 54% as a percentage of household expenditure.[48]

In December 2018, the first phase of UHC rolled out in four counties (Kisumu, Nyeri, Machakos, and Isiolo) with the goal of scaling up to all 43 counties after the first year.[49] The rollout of the pilot phase has resulted in the Kenyan president, Uhuru Kenyatta, receiving the UHC Political Leadership award.[50] Despite this international acclaim, we shall outline below how both the priority setting and pilot phase selection process fell short in terms of the imperative of participatory decision making processes.

Priority setting is a key component of UHC because states have to make choices about what and how to finance health.[51] From a human rights perspective, this process should be equitable, non-discriminatory, participatory, transparent, and accountable.[52] The health system has to be understood as part of democratic governance and thus the questions to be answered are not merely technical but require active participation of citizens in decisions regarding their health, a key principle of the right to health care.[53] In this respect, the Ken-

yan experience of rolling out UHC is illustrative of the normative gaps between the commitments under UHC2030 (Joint Vision and the Global Compact) and the international framework on the right to health, as well as the Kenyan framework on participatory decision making as captured in national values.[54] The decision as to what should form a priority when selecting pilot counties was not taken in a participatory manner and the basis for the decisions was communicated mainly after the pilot counties had been chosen. The choice of the UHC pilot counties suggests selection criteria that lean heavily towards curative medicine, a legitimate choice but one taken without appropriate consultation.[55] The counties selected for the pilot phase include one with a prevalence of communicable diseases (malaria and HIV in Kisumu); one with non-communicable diseases (hypertension, diabetes, and cancer in Nyeri); another with a high incidence of injuries caused by road accidents (Machakos); and one with a high maternal mortality ratio (Isiolo).[56] Many Kenyan government UHC documents refer to essential health care services, however; the definition of essential health care service remains unclear and was not communicated before the rollout of UHC. Enabling citizens and civil society to meaningfully participate in ranking and criteria for priorities is time consuming, expensive, and challenging given the information asymmetries and the diverse interests, but it is fundamental to a rights-based approach and necessary for accountability, transparency, and legitimacy in decision making.[57] At present, there is no guidance on definitions, and no public discourse to outline the essential components of health care in Kenya.

The consequences of failing to democratize the process of priority setting and decision making regarding the right to health and access to health care were apparent at the Third UHC Conference in Kisumu County on May 15-17, 2019. The first problem relates to participatory decision making. The final conference communique seeks to demonstrate that a consensus was reached between the government and other stakeholders, including civil society, yet many civil society participants were prevented from participating. Further, the final communique did not take into account the position statement of 26 civil society organizations working with Kisumu County communities, who were not given the opportunity for meaningful participation in the process.[58]

The second problem relates to the sequencing of the rollout of UHC in Kisumu. The conference took place in May 2019, yet residents had begun registering for UHC in January 2019.[59] In January, the policy basis for the registration process was not in place and the government had not shared any information to allow residents to make an informed decision on their health.

Finally, the participation of marginalized and vulnerable groups was lacking. Kisumu County was chosen as a pilot county because of the high burden of communicable diseases (HIV and malaria), but there is no evidence from the communique to underscore or amplify the voices of marginalized groups (such as women, sex workers, adolescent girls and young women, and men who have sex with men). This notable exclusion raises concern that the needs of these communities will not be prioritized and the objective of addressing health equity may fall short as a result.

One of the primary reasons for the devolution of health in Kenya was to bring decision making closer to those affected by the decision. However, the manner in which UHC has thus far rolled out mimics the paternalistic past, with the national government making decisions and merely communicating them to counties for implementation. The counties also appear to be playing the role of implementer and not assuming their role as a separate government responsible for delivering on the right to health and respecting the national values.

The failure to engage in the appropriate county-level consultations risks the legitimacy of the entire UHC campaign. This approach is not in line with UHC2030 commitments, and UHC2030 could play a role in bringing diverse stakeholders together to try to reorient the Kenyan UHC2030 on a legitimate path that reflects the right to health commitments in the constitution. As currently framed, the path to UHC in Kenya is a heavily politicized objective that has been prioritized without

consultations at the appropriate political level.

Uganda

In Uganda, both participation in decision making and the prohibition of discrimination against vulnerable and marginalized groups are constitutional rights.[60] The National Health Policy and the Health Sector and Development Plan call upon the government to actively promote community participation in health service delivery and management by empowering communities, households, and individuals to take greater responsibility for their own health and the management of local health services. Despite these progressive constitutional and policy provisions, sections of the Ugandan population continue to witness and experience discrimination and poor service delivery. As Mulumba et al. have noted, a key reason for the poor health of persons with disabilities and the elderly is "political sidelining, discrimination and inequitable access to health services."[61] It is therefore important that the commitments towards nondiscrimination and addressing the needs of the vulnerable move beyond policy commitments to actualization.

For Uganda, the value of UHC 2030 is tied to how it "cements the role of civil society in holding governments to account for what they have promised to deliver" vis à vis financing, as called for in the CSEM-P.[62] The principles included in the Joint Vision and Global Compact need to move from theory to implementation at the country level, including through means like the CSEM.

The participatory structures for communities in the health system in Uganda include health committees for the management of health facilities which Mulumba et al. have described as "having a potentially significant role in ensuring effective participation of communities in the provision of health services."[63] However, these committees "can only play their role of promoting participation as an integral part of the right to health and improve health care delivery where they have the requisite education, training, and tools."[64] This suggests that UHC2030 needs to pay special attention to the role of such participatory structures at the national level.

With respect to the principle of minimum core obligations, Uganda's national health policy provides for the Uganda National Minimum Health Care Package (UNMHCP) defined as "the most cost-effective priority healthcare interventions and services addressing the high disease burden that are acceptable and affordable within the total resource envelope of the sector."[65] The government's policy objective is ensuring "universal access to quality UNMHCP consisting of promotive, preventive, curative and rehabilitative and palliative services for all prioritized diseases and conditions, to all people in Uganda, with emphasis on vulnerable populations."[66] While the policy does not present the UNMHCP as a rights issue, it emphasizes the need to ensure that "all people in Uganda, both users and providers of health services, understand their health rights and responsibilities through implementation of comprehensive advocacy, communication and social mobilization programs."[67] This has various implications for the UHC 2030 agenda. For example, UHC2030 efforts need to connect with the country level to ensure progressive and sustained implementation of the UNMHCP as spelled out in the national constitution, policies, and plans.

Active engagement of UHC2030 with the Global Compact pledge of

> *building and expanding equitable, resilient and sustainable health systems, funded primarily by public finance, and based on primary health care, that deliver integrated, comprehensive people-centered and quality health services for all, while taking necessary measures to protect households from financial hazards due to health expenditures*

could help Uganda advance on its core right to health commitments related to maternal mortality. The Ugandan government is subject to a constitutional challenge for failure to provide the essential maternal health commodities listed in the UNMHCP. Through a constitutional petition, the Ugandan civil society group CEHURD and others have argued that the non-provision of basic indispensable maternal health commodities in government health facilities is inconsistent with the constitution and a violation of its right to health obligations.[68] This

case also argued that the high number of preventable maternal deaths (the 2015 maternal mortality ratio stood at 343 deaths per 100,000 live births) is also caused by the government's non-provision of the basic minimum maternal health care packages, constituting a violation of the right to health.[69] While the Constitutional Court upheld a preliminary objection on the courts incapacity to interpret the matter before it because of the 'political question doctrine', the Supreme Court overturned this decision and held that it was the duty of the court to "to interpret what amounts to taking all practical measures to ensure the provision of basic medical services."[70] The Supreme Court further argued that "the court should be able to receive evidence on the measures being taken by government to satisfy itself that they fall within objective XX."[71]

While this matter is still before the court, the Supreme Court decision suggests how UHC2030 could work with civil society and the Ugandan government to ensure that the government prioritizes what needs to be done at the country level to fulfill its constitutional right to health obligation to provide basic medical care. In this way, UHC2030 could demonstrate leadership in global health governance that advances health rights.

Conclusion

From a health rights perspective, there is a need to continue interrogating how progress on UHC will be pursued by different global health actors to assess whether or not it advances rights-based global health governance. If embedded in the right to health and subjected to the constant interrogation of civil society partners, it has the potential to transform the lives of millions of people by ensuring that no one is left behind. Without the anchor of rights, a purely technical approach to advancing UHC risks mirroring the global and national patterns of exclusion and injustice that flow from the colonial era. The nature of the process of deciding national UHC packages, ongoing shortfalls in domestic financing, and a retreat from international engagement and funding from wealthy countries are likely to become the key points of struggle around issues of affordability and inclusion. From a human rights perspective, this is where civil society will be very important in ensuring that UHC is compliant with demands regarding the right to health. The challenge for UHC2030 partners in the coming years will be overcoming the gaps between UHC, and UHC anchored in the right to health care, so that it ensures that its demands for UHC contribute to advancing the right to health care for all.

References

1. United Nations General Assembly (UNGA), Res. 70/1, UN Doc. A/RES/70/1 (2015).

2. World Health Organization, *Positioning health in the post-2015 development agenda* (Geneva: World Health Organization, 2012). Available at http://www.who.int/topics/millennium_development_goals/post2015/WHOdiscussionpaper_October2012.pdf.

3. R. Horton and P. Das, "Universal health coverage: not why, what, or when–but how?" *Lancet*. 28;385/9974, (2015), pp. 1156–7. doi: 10.1016/S0140-6736(14)61742-6.

4. G. Ooms and K. Kruja,"The integration of the global HIV/AIDS response into universal health coverage: desirable, perhaps possible, but far from easy." *Globalization and Health*. 15(1), (2019) pp. 41.

5. United Nations General Assembly, Scope, modalities, format and organization of the high-level meeting on universal health coverage" 13 December 2018. A/RES/73/131. Available at https://undocs.org/en/A/RES/73/131.

6. UHC2030, Available at https://www.uhc2030.org/

7. UHC2030, "Six Asks". Available at https://www.uhc2030.org/news-events/uhc2030-news/uhc2030-launches-key-asks-from-the-uhc-movement-for-the-un-high-level-meeting-on-universal-health-coverage-544846/.

8. G. Ooms, L.A., Latif, A. Waris, et al., "Is universal health coverage the practical expression of the right to health care?" *BMC International Health and Human Rights*, 14:3, (2014).

9. Equinet and CEHURD, *Review of constitutional provisions on the right to health in Uganda: A case study report* (2018). Available at: https://www.equinetafrica.org/sites/default/files/uploads/documents/CEHURD%20Constitutional%20Review%20Sep2018.pdf; Equinet and KELIN, *Mapping the constitutional provisions on the right to health and the mechanisms for implementation in Kenya: Case study report* (2018). Available at: http://www.equinetafrica.org/sites/default/files/uploads/documents/KELIN%20Kenya%20rights%20case%20study%202018.pdf.

10. D. Sridhar, C.E. Brolan, S. Durrani, et al., "Recent Shifts in Global Governance:Implications for the Response

to Non-communicable Diseases." *PLoS Med* 10/7 (2013) p. e1001487.

11. Institute for Health Metrics and Evaluation. *Financing Global Health. Table B5 Flows of Development Assistance for Health, from source to channel to health focus area, 1990-2017* (2018). Available at http://www.healthdata.org/policy-report/financing-global-health-2017.

12. The United Nations Sustainable Development Solutions Network (UNSDSN). Health in the Framework of Sustainable Development. (2013) Available at http://unsdsn.org/thematicgroups/tg5/tg5_resources/.

13. International Covenant on Economic, Social and Cultural Rights (ICESCR), G.A. Res.2200A (XXI), Art. xx. (1966). Available at http://www2.ohchr.org/english/law/cescr.htm.

14. C. Brolan, P.S. Hill and G Ooms, "Everywhere but not specifically somewhere: a qualitative study on why the right to health is not explicit in the post-2015 negotiations." *BMC International Health and Human Rights* 15:22, (2015). doi 10.1186/s12914-015-0061-z.

15. UNGA (see note 1).

16. Brolan (see note 14) also see J. L. Sturchio, I. Kickbusch and L. Galambos (eds). *The Road to Universal Health Coverage Innovation, Equity, and the New Health Economy* (John Hopkins University Press, Baltimore, 2019).

17. R. Van de Pas R, et al. Global Health governance in the sustainable development goals: is it grounded in the right to health? *Global Challenges* 1/1 (2017). p. 47–60. doi: 10.1002/gch2.1022.

18. Ooms (see note 8).

19. Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14, The Right to the Highest Attainable Standard of Health, UN Doc. No. E/C.12/2000/4 (2000). Available at http://www.unhchr.ch/tbs/doc.nsf/0/40d009901358b0e2c1256915005090be?Opendocument.

20. Ibid.

21. Ibid.

22. R. Hammonds and G. Ooms. (2018) "National foreign assistance programs", in B.M. Meier and L.O. Gostin ed. *Human Rights in Global Health: Rights Based Governance for a Globalizing World.* (Oxford University Press, 2018).

23. J. Tobin, *The Right to Health in International Law* (Oxford: Oxford University Press, 2012). pp. 342.

24. Ooms (see note 8).

25. S.G. Morgan and K. Boothe. "Universal prescription drug coverage in Canada: Long-promised yet undelivered." *Healthcare Management Forum*. 29/6 (2016), pp. 247–254. doi:10.1177/0840470416658907.

26. Ooms (see note 8).

27. Organisation for Economic Cooperation and Development (OECD). *The Paris Declaration on Aid Effectiveness*. 2005. Available at http://www.mfdr.org/sourcebook/2-1paris.pdf OECD.

28. UHC2030 *History.* https://www.uhc2030.org/about-us/history/.

29. S. Conway and T. Shorten, "The International Health Partnership" in E. Beracochea (ed), *Improving Aid Effectiveness in Global Health,* (New York: Springer, 2015) 111-118.

30. UHC2030, *History.* Concept Note, 2016 Available at https://www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/About_UHC2030/mgt_arrangemts___docs/UHC2030_transformation/UHC_2030_Concept_Note_17_June_.pdf.

31. UHC2030, Global Compact https://www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/About_UHC2030/mgt_arrangemts___docs/UHC2030_Official_documents/UHC2030_Global_Compact_WEB.pdf.

32. O. Ogbuoji and G. Yamey. "Aid effectiveness in the Sustainable Development Goals era:" Comment on "It's about the idea hitting the bull's eye": how aid effectiveness can catalyse the scale-up of health innovations." *International Journal of Health Policy and Management*. 8/3, (2019), pp.184–186. doi:10.15171/ijhpm.2018.130.

33. UHC2030, (see note 7).

34. UHC 2030. "Healthy systems for universal health coverage – a joint vision for healthy lives" (Joint Vision) Available at https://www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/About_UHC2030/mgt_arrangemts___docs/UHC2030_Official_documents/UHC2030_vision_paper_WEB2.pdf.

35. UHC2030 Civil Society Engagement Mechanism (CSEM 'On the Road to UHC: Leave no one behind: A civil society organisation (CSO) perspective on how Universal Health Coverage (UHC) can be reached by 2030' Available at: https://www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/Key_Issues/UHC2030_civil_society_engagement/ON_THE_ROAD_TO_UHC_CSEM_2018__1_.pdf; UHC2030 CSEM Website https://csemonline.net/advocacy-collaboratives/.

36. Ibid.

37. L. Forman, L. Caraoshi, A. Chapman and E. Lamprea. "Conceptualizing the 'morality of the depths': How should we define and implement core obligations under the right to health?" *International Journal of Human Rights* 20:4, (2016), pp. 531-548.

38. Aidsfonds, PITCH. *Towards transformative integration of the HIV/AIDS response into Universal Health Coverage: Building on the strengths and successes of the HIV and AIDS response* (2019) Available at https://aidsfonds.org/assets/resource/file/0034-PITCH_Global%20Report_WEB%20%282%29.pdf.

39. For example see the list of partners that aidsfonds works with https://aidsfonds.org/partner.

40. World Bank. *High-Performance Health Financing for Universal Health Coverage: Driving Sustainable, Inclusive Growth in the 21st Century - Executive Summary (English).* (Washington D.C.: World Bank Group, 2019). Available at http://

documents.worldbank.org/curated/en/573741561043458314/Driving-Sustainable-Inclusive-Growth-in-the-21st-Century-Executive-Summary.

41. Aidsfonds (see note 39).

42. Institute for Health Metrics and Evaluation (IHME). *Financing Global Health 2018: Countries and Programs in Transition*. Seattle, WA: IHME, 2019.

43. A. Haakenstad, MW Moses, T. Tao et al., "Potential for additional government spending on HIV/AIDS in 137 low-income and middle-income countries: an economic modelling study," The Lancet HIV, 19 (2019), pp. 30165-324.

44. R. Smith, "Global Health Governance and Global Public Goods" in K. Buse, H. Wolfgang and N. Drager N (eds), *Making sense of global health governance. A policy perspective.* (London: Palgrave Macmillan, 2009). pp. 122-136.

45. Equinet (see note 9).

46. Article 43(1) (a) of the Constitution of Kenya, 2010.

47. E. Wangia and K. Charles. "Refocusing on quality care and increasing demand for services; Essential elements in attaining universal health coverage in Kenya", Ministry of Health, UNFPA, WHO, World Bank, Government of Japan. (2019) Available at http://www.health.go.ke/wp-content/uploads/2019/01/UHC-QI-Policy-Brief.pdf.

48. Government of Kenya. (GOK) "Fast tracking our vision through a 5-year development plan under 4 key pillars." Available at https://big4.president.go.ke/.

49. M. Musyoki "Why Machakos, Isioli, Kisumu, Nyeri were selected for pilot universal health coverage" 9 October 2018., Available at https://www.kenyans.co.ke/news/33829-why-machakos-isiolo-kisumu-nyeri-were-selected-pilot-universal-health-coverage.

50. Ministry of Health, Kenya 'UHC political leadership award' available at http://www.health.go.ke/uhc-political-leadership-award/. Also see Kimuyu H 'Kenyans roll eyes after Uhuru wins universal healthcare award' 25 September 2019, Nairobi News. Available at https://nairobinews.nation.co.ke/featured/kenyans-roll-eyes-after-uhuru-wins-universal-healthcare-award.

51. A. Yamin and A. Maleche "Realizing Universal Health Coverage in East Africa: the Relevance of human rights" *BMC International Health and Human Rights* 17:21 (2017). doi 10.1186/s12914-017-0128-0.

52. Wangia (see note 47) and GOK (see note 48).

53. Wangia (see note 47).

54. Article 10 of the Constitution of Kenya, 2010 enshrines equity, public participation, accountability and transparency as values that should govern all laws and practice in Kenya.

55. Wangia (see note 47) and GOK (see note 48).

56. M. Musyoki "Why Machakos, Isioli, Kisumu, Nyeri were selected for pilot universal health coverage" 9 October 2018. Available at https://www.kenyans.co.ke/news/33829-why-machakos-isiolo-kisumu-nyeri-were-selected-pilot-universal-health-coverage.

57. Government of Kenya (Council of Governors). "Launch of Universal Health Coverage Pilot" (18 December 2018). Available at https://www.kelinkenya.org/wp-content/uploads/2019/05/UHC-Position-Statement-by-Kisumu-CSO-at-the-3rd-UHC-Conference_17052019.pdf.

58. See the Position Paper submitted by 26 CSOs, including KELIN. Available at https://www.kelinkenya.org/wp-content/uploads/2019/05/UHC-Position-Statement-by-Kisumu-CSO-at-the-3rd-UHC-Conference_17052019.pdf.

59. Kisumu County Government. "Kisumu UHC mop up begins" (24 January 2019). Available at https://www.kisumu.go.ke/news-item/kisumu-uhc-mop-up-exercise-begins/.

60. The Republic of Uganda, "The Constitution of the Republic of Uganda" (1995).

61. Mulumba et al. "Perceptions and experiences of access to public healthcare by people with disabilities and older people in Uganda". *International Journal for Equity in Health* 13:76 (2014).

62. UHC2030 CSEM (see note 35).

63. M. Mulumba, L. London, L., J. Nantaba and C. Ngwena "Using Health Committees to Promote Community Participation as a Social Determinant of the Right to Health: Lessons from Uganda and South Africa". *Health and Human Rights Journal*, 20/2, (2018), pp. 11–17.

64. Ibid.

65. The Republic of Uganda 'The Health Sector Development Plan" 2015. Available at https://nutrition.opm.go.ug/index.php/implement/health/health-sector-development-plan-hsdp-201516-201920/.

66. Ibid.

67. Ibid.

68. Constitutional Petition No. 16 of 2011 – *Centre for Health, Human Rights and Development & Others v. Attorney General of Uganda*. Available at: https://www.globalhealthrights.org/africa/center-for-health-human-rights-and-development-cehurd-v-attorney-general/.

69. UNICEF, Maternal and Newborn Health Disparities; Uganda (2016). Available at https://data.unicef.org/wp.../Uganda/country%20profile_UGA.pdf.

70. Constitutional Appeal No. 01 of 2013- *Centre for Health, Human Rights and Development and Three Others v. Attorney General of Uganda*, Supreme Court of Uganda at Kampala. 2015. Available at https://www.escr-net.org/sites/default/files/caselaw/cehurd_and_others_v_attorney_general.pdf.

71. Ibid. pp. 51.

The Challenge of Interdisciplinarity in Operationalizing the Right to Health

GILLIAN MACNAUGHTON AND MARIAH MCGILL

Abstract

Interdisciplinary collaboration between the health and human rights communities is essential to operationalize the right to health. In practice, however, such collaboration has been infrequent. As noted by Jonathan Mann et al., the fields of health and human rights have "differing philosophical perspectives, vocabularies, professional recruitment and training, societal roles, and methods of work." These differences have posed barriers to interdisciplinary collaboration. This article focuses on interdisciplinarity—especially between health and human rights communities—as key to realizing the right to health. Drawing on interviews with experts on health and human rights, the article explores the challenges of interdisciplinarity at the Office of the High Commissioner for Human Rights (OHCHR), the United Nations (UN) agency charged with mainstreaming human rights, including the right to health, across the UN system. To operationalize the right to health, experts perceive the need (1) to move beyond legalistic concepts of the right to health; (2) to enhance appreciation of the right to health across UN agencies; (3) to employ health professionals at the OHCHR; (4) to develop deep expertise on the right to health to advise on operationalization; and (5) to understand the right to health as an expanded right that includes the social determinants of health.

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Introduction

Scholars and practitioners working to advance the right to health have long recognized that interdisciplinary collaboration between the health and human rights communities is essential to realize the right to health for all. In practice, however, such collaboration, has been infrequent. As Mann et al. noted in the first issue of the *Health and Human Rights Journal* in 1994, the fields of health and human rights have "differing philosophical perspectives, vocabularies, professional recruitment and training, societal roles, and methods of work."[1] Moreover, the concepts of health, human rights, and the right to health are complex and continually evolving.[2] Health workers not familiar with the right to health may view rights as primarily a basis for litigation and therefore shy away from them. Human rights practitioners may have little appreciation for the extent to which health is implicated in the realization or violation of all human rights. Indeed, a history of conflicts between practitioners in medicine and law, as well as between public health officials and civil liberties advocates, may prejudice human rights and health communities against each other.[3] Yet both the health and human rights communities are centrally concerned with improving human well-being.

Further, there is no possibility of realizing the right to health for all without human rights experts who focus on and develop expertise on the right to health, as well as health professionals in both public health and medicine who understand and integrate human rights generally and the right to health specifically into their work. Indeed, only through interdisciplinary collaboration between scholars and practitioners in a wide range of social sciences can we mainstream the right to health into policies, planning, institutions, management practices, programs, projects, and operations. And only through mainstreaming the right to health into all aspects of society can we fully operationalize the right to health. While some progress has been made in the 25 years since Mann and colleagues published their article, the problem remains that few health professionals today understand and use the right to health in their work, and few human rights lawyers and practitioners today understand and appreciate the right to health.

In his 2005 address to the United Nations Commission on Human Rights, Kofi Annan stated:

> *The cause of human rights has entered a new era. For much of the past 60 years, our focus has been on articulating, codifying and enshrining rights. That effort produced a remarkable framework of laws, standards and mechanisms—the Universal Declaration of Human Rights, the international covenants, and much else. Such works needs to continue in some areas. But the era of declaration is now giving way, as it should, to an era of implementation.*[4]

While the "era of declaration" called specifically for philosophers and legal scholars to conceptualize and draft human rights instruments, the "era of implementation"—or operationalization—requires interdisciplinary collaboration with health professionals and experts in many more fields. Only with diverse expertise can we solve the complex puzzles necessary to operationalize the right to health. Only through interdisciplinary collaboration can we mainstream the right to health into all United Nations (UN) entities and all sectors of government.

The Office of the High Commissioner for Human Rights (OHCHR) is the division of the UN responsible for mainstreaming human rights, including the right to health, across the UN system, and it also takes a lead role in advising governments on implementing the right to health in national contexts. For this reason, this article focuses specifically on the opportunities and challenges of interdisciplinarity faced by the OHCHR in operationalizing the right to health. Paul Hunt, former Special Rapporteur on the right to health, has recently noted that "human rights mainstreaming requires that those working in the field of health and human rights listen to, and learn from, each other with a view to enhancing the rights, dignity, and well-being of individuals, communities, and populations."[5] He has "the impression that the High Commissioner and OHCHR have approached their mainstreaming mandate with vigor and made notable progress, despite major structural and financial constraints."[6]

In 2018, the authors of this article published a chapter on the evolution of the right to health at the OHCHR that drew on (1) archival records of the publications and initiatives related to the right to health at the OHCHR; (2) the annual reports of the High Commissioner for Human Rights on the activities of the OHCHR; and (3) semi-structured interviews with 20 experts on the right to health (or economic and social rights more generally), including 10 current and former employees of the OHCHR and 10 external experts who have worked with the OHCHR.[7] In that chapter, we identified four factors that have affected the mainstreaming of the right to health at the OHCHR since 1994. On the positive side, there has been increasing acceptance of economic and social rights as real human rights, and there have been right-to-health champions among OHCHR leadership. On the negative side, the OHCHR has extremely limited capacity and resources for its global human rights mandate, and it faces considerable challenges in moving beyond legal conceptualization to operationalization of the right to health in practice.[8]

In this article, we expand on the last of these factors to discuss in more depth the challenge of interdisciplinarity in the OHCHR's operationalization of the right to health. We draw on the burgeoning literature on interdisciplinarity and human rights and the data (archival records, annual reports, and interviews) we collected for the 2018 chapter. Additionally, we draw on four follow-up interviews conducted in July 2019 with interviewees (both inside and outside the OHCHR) concerning the entity's recent work on the right to health, specifically the impact of the 2018 Framework of Cooperation between OHCHR and the World Health Organization (WHO) and the change of High Commissioner for Human Rights in 2018. The article, therefore, both narrows in on the question of interdisciplinarity and updates our previous work on the right to health at the OHCHR.[9]

Following this introduction, the article proceeds in three parts. First, it provides a brief overview of the structure of the OHCHR and where the work on the right to health falls within that structure. Second, it reviews literature on interdisciplinarity and human rights, focusing specifically on the right to health. Third, with the background on the OHCHR and interdisciplinarity, it examines the opportunities and challenges faced by OHCHR employees in carrying out interdisciplinary and inter-organizational work to operationalize the right to health.

Office of the United Nations High Commissioner for Human Rights

The 1993 World Conference on Human Rights adopted the Vienna Declaration and Programme of Action, which recommended that the UN General Assembly consider "the question of the establishment of a High Commissioner for Human Rights for the promotion and protection of all rights."[10] Later that year, the General Assembly adopted a resolution creating the post and affirmed that the High Commissioner was responsible for protecting and promoting civil and political, and economic, social, and cultural rights alike.[11] Initially, the OHCHR was housed in Geneva and employed six staff.[12] Today, it employs more than 1,300 people, the majority at the head office in Geneva, and others in OHCHR regional or country offices and in UN field presences across the globe.[13]

Broadly, the mandate of the OHCHR is to protect and promote human rights around the world.[14] The OHCHR has four areas of responsibility. First, it supports the UN human rights mechanisms including the Human Rights Council, the 10 human rights treaty bodies, and the 57 Special Procedures (including the Special Rapporteur on the right to health).[15] For example, in 2018, the OHCHR organized a consultation on mental health and human rights at the request of the Human Rights Council.[16]

Second, the OHCHR develops policy guidance, tools, trainings, and methodologies to provide member states and civil society with practical approaches to implementing human rights.[17] Recent examples include *Human Rights, Health and Poverty Reduction Strategies*, published in 2008, and *Reproductive Rights are Human Rights: A Handbook for National Human Rights Institutions*, published in 2014.[18]

Third, the OHCHR advises UN agencies on mainstreaming human rights into all their programs. Through UN inter-agency bodies and activities, the OHCHR has advised, for example, on mainstreaming human rights into the Sustainable Development Goals, gender equality and human rights into multilateral environmental agreements, and disability rights across the UN system.[19] Recently, in September 2019, the OHCHR was closely involved in the high-level meeting on universal health coverage held at the UN General Assembly.[20]

Fourth, as of 2018, the OHCHR operated 17 country offices and 12 regional offices, and supported 77 field presences.[21] In the field, the OHCHR helps UN country teams and governments respond to crises, draft legislation, train government officials, and implement recommendations of the human rights mechanisms.[22] For example, in 2018, through its Colombia office, the OHCHR provided technical support that enabled the governor of Amazonas and indigenous communities to reach agreement to advance the implementation of a comprehensive intercultural health system.[23]

All four areas of OHCHR responsibility involve interdisciplinary work. Thus, an interdisciplinary team to work on the right to health would be ideal. Currently, however, the OHCHR employs one staff member whose sole focus is on the right to health, as well as one staff member to assist the Special Rapporteur on the right to health in carrying out his independent mandate. Nonetheless, because health issues are often interconnected with other rights, staff assigned in other areas—such as children's rights, women's and gender rights, environmental rights, and the Sustainable Development Goals—also engage the right to health in their work. OHCHR staff employed in country and regional offices also regularly engage in health-related work.

In recent years, one particular focus of the OHCHR has been on the health rights of women, children, and adolescents. In 2016, the OHCHR established, in collaboration with WHO, the High-Level Working Group for Health and Human Rights of Women, Children and Adolescents.[24] The purpose of the High-Level Working Group was to secure national and international political support for the implementation of the human rights-related measures of the Global Strategy for Women's, Children's and Adolescent's Health (2016–2030).[25] After a year-long consultation with more than 200 individuals and organizations, the High-Level Working Group issued a report in 2017.[26] In its report, the working group notes that health cannot be improved without human rights and asserts the need for sustained, committed leadership at the national and international level to secure human rights to and through health.[27]

The recommendations in the 2017 report are divided into three areas. First, *creating an enabling environment* includes recommendations to uphold the right to health in national law and address human rights as determinants of health.[28] Second, *partnering with people* includes recommendations on enabling people to claim their rights and empowering human rights advocates and defenders.[29] Third, *strengthening evidence and public accountability* focuses on collecting rights-sensitive data and reporting systematically on health and human rights.[30] Additionally, the report called on the OHCHR and WHO to launch a joint program of work to support the implementation of these recommendations at the regional and country level.[31]

In November 2017, the OHCHR and WHO signed a framework of cooperation to implement the recommendations of the working group and deepen collaboration between the two organizations.[32] Specifically, the framework pledges the two organizations to collaborate in the following areas: (1) supporting the advancement of international norms and standards for the realization of the right to health; (2) advancing national-level implementation of human rights standards; (3) enhancing the capacity of member states and other national partners to monitor health and human rights; and (4) cooperating in research and development of guidance to address priority areas related to health and human rights.[33] WHO and the OHCHR have worked together in the past, but the framework of cooperation ushers in a new, deeper relationship between the two organizations and may foster more collaboration between public health and human rights profession-

als. As the Working Group report points out, such collaboration is important because it can "expand the ways in which problems are identified, deepen analysis, strengthen the setting of priorities and tailor more effective interventions."[34]

The OHCHR's efforts to strengthen collaboration with public health and medical professionals may also be supported by the appointment of Michelle Bachelet as the new High Commissioner for Human Rights in September 2018. Bachelet is the former president of Chile and was the first director of UN Women. Notably, Bachelet has a medical degree with a specialization in pediatrics and public health, making her the first High Commissioner with a health background.[35] A High Commissioner with expertise in health has a unique perspective and experience that could help to operationalize the right to health. Although it is too soon to know the impact of Bachelet's appointment, her strong background in both health and human rights is a promising development.

Interdisciplinarity in human rights research and practice

Since the 1970s, there has been increasing interest in interdisciplinary research, theory, knowledge, and education.[36] Dictionaries define "discipline" as a field of study or a branch of knowledge, instruction, learning, or education.[37] A more specific definition is a "self-contained and isolated domain of human experience which possesses its own community of experts."[38] In contrast, "'[i]nterdisciplinarity' is a synthesis of two or more disciplines, establishing a new level of discourse and integration of knowledge."[39] For example, interdisciplinary researchers developed new treatments for cancer by combining medicine with nuclear physics.[40] New disciplines, such as biochemistry, may eventually emerge from interdisciplinary work.[41] Unlike interdisciplinarity, "multidisciplinarity" juxtaposes disciplines but does not integrate them—for example, a series of lectures on a topic by people in different disciplines.[42]

Interdisciplinary research and knowledge also presents many opportunities to improve human well-being. In his article "Ten Cheers for Interdisciplinarity," Moti Nissani argues that combining disciplines provides opportunities for creative breakthroughs, aids in addressing complex or practical problems, emphasizes the unity of knowledge, allows for flexibility in research, and contributes to social change.[43] Similarly, Bernard Choi and Anita Pak maintain that teamwork involving multiple disciplines helps resolve real-world problems, provide different perspectives on a problem, create a comprehensive theory-based hypothesis for research, develop consensus guidelines for complex diseases and conditions, and provide comprehensive health care services and health education.[44]

There are challenges to interdisciplinarity as well. An interdisciplinarian is unlikely to be able to master multiple disciplines as well as a specialist can master one discipline.[45] A jack of all trades will likely be a master of none.[46] Additionally, it is very demanding for the interdisciplinarian—in terms of time and intellectual energy—to keep up in more than one discipline.[47] Further, while a broader interdisciplinary perspective may lead to new perspectives and new knowledge, it may also provide more opportunities for mistakes. Finally, interdisciplinary research teams may call for collaboration of experts in different disciplines who have different ways of thinking and communicate in different languages, which is "a notoriously difficult undertaking."[48] Despite these challenges, in recent years there has been a surge of interdisciplinary research, practice, and education.

Human rights is an interdisciplinary concept par excellence.[49] While human rights was dominated largely by philosophers and lawyers in the first several decades after the establishment of the United Nations in 1945, scholars and practitioners in many other fields have become involved in human rights, especially since the 1993 World Conference on Human Rights. At that conference, there was a reaffirmation of the indivisibility, interdependency, and interrelatedness of all human rights, which catapulted economic, social, and cultural rights back on to the mainstream human rights agenda.[50] Human rights scholars and practitioners then recognized that, for example, indicators would be

necessary to monitor the progressive realization of economic, social, and cultural rights over time. Further, budget analysis would be necessary to assess whether governments were using maximum available resources to realize these rights. These practices called for the expertise of social scientists, statisticians, and others.

The World Conference on Human rights also reaffirmed the right to development.[51] The 1990s, therefore, also saw the new field of legal anthropology emerge to address the role of—and conflicts between—international human rights norms in local processes of social change.[52] At the same time, development economists began to engage with human rights to provide practical guidance for development policies that would comply with international human rights legal obligations.[53] Since 2000, there has been an increasing diversity of disciplinary interest in human rights, including by historians, theologians, literary critics, political scientists, sociologists, economists, and anthropologists, as well as by people in interdisciplinary fields, such as women's studies, labor studies, public health, and critical theory. Today, human rights is a multidisciplinary and interdisciplinary field—although not yet a discipline—and there is a burgeoning literature on interdisciplinarity in human rights education, research, and practice.[54]

Much of the focus on interdisciplinarity and the right to health has been on encouraging collaboration between the health and human rights communities. This linkage seems obvious; expertise in both health and human rights is necessary to realize the right to health. This limited understanding of interdisciplinarity and the right to health grew out of the disease-specific origins of the health and human rights movement, which focused on HIV/AIDS in the late 1980s and early 1990s. Working together, human rights and health communities called for respecting human rights (to confidentiality, informed consent, and nondiscrimination) to gain the trust of those affected in order to get their help in reducing the spread of the disease. Today, we understand that the potential for interdisciplinary collaboration on health and human rights extends beyond the health and human rights communities to many disciplines and interdisciplinary fields.

Importantly, the right to health is now understood to be a broad right that includes the social determinants of health—the conditions in which we live and work—such as education, housing, environment, work conditions, and health care, as well as discrimination, economic power imbalances, and violence. Given that the right to health is a complex right affected by a wide range of legal, political, economic, cultural, and social determinants, its operationalization for all requires the collaboration of a wide range of disciplinary and interdisciplinary experts. Anthropologists, economists, sociologists, political scientists, geographers, and historians are needed to research, for example, people's attitudes toward the right to health in different communities and over time, the impact of human rights-based approaches to health, what methods best measure progress in the realization of the right to health, and whether right-to-health litigation helps the wealthy or the poor. Only fully interdisciplinary collaboration across multiple disciplines will enable the full operationalization of the right to health for all across all sectors of our complex societies.

Findings on OHCHR and interdisciplinarity

According to the experts we interviewed, fully operationalizing the right to health will require (1) moving beyond legalistic concepts of the right to health; (2) enhancing appreciation of the right to health across UN agencies; (3) employing health professionals at the OHCHR; (4) developing deep expertise on the right to health to advise on operationalization; and (5) understanding the right to health as an expanded right that includes the social determinants of health.

Moving beyond legalistic concepts of the right to health

Many of the interviewees in our study recognized that interdisciplinary work is essential to realizing the right to health. First, as one of our interview-

ees explained, "Health is not one topic."[55] Health involves health policy, health care services, health care insurance, health education, health research, and the social determinants of health, which include all the conditions in which we live and work. Thus, even within public health, there are many disciplines. Second, few people are educated in both health and human rights. One interviewee remarked, "Even though there is a growing convergence of people who are looking at public health and human rights, I think having a technical capacity that's both legal and public health is still quite a rare skill set."[56]

In this context, several interviewees discussed the challenges of communicating across disciplines as an impediment to operationalizing the right to health. One interviewee explained:

> *You still have people who are either human rights people, or who are public health people, but you don't have a huge number who really can comfortably cover both. And that's a challenge. … Being able to speak each other's language is a constant learning process, even for us within our team. That's a challenge to mainstreaming because you're trying to educate people on a discipline that is completely foreign to them.*[57]

Some interviewees reported the sense that legal and public health professionals often did not speak the same language. Nonlawyers described human rights language of the OHCHR as "too legalistic." In their view, the OHCHR's overreliance on a technical-legal approach to human rights does not leave room for health practitioners to engage with them. One interviewee explained that this legalistic approach to the right to health resulted in creating distance between OHCHR staff and those working on the ground.[58] Another interviewee explained:

> *[S]ometimes the right to health in the discussions in OHCHR becomes very conceptual, legalistic, but I would like to see OHCHR moving forward into putting into practice the right to health … [and] doing something at the country level.*[59]

While several interviewees observed that health professionals often viewed human rights as dry legal concepts that were irrelevant to their work, one interviewee felt that the differences due to discipline are overstated and often used as an excuse to minimize the mainstreaming of the right to health into UN initiatives:

> *I don't think we speak different languages. … It's, in some sense, a false barrier that people use to justify not cooperating on different issues or not integrating a human rights approach, for example. The human right to health and human rights generally are to be mainstreamed throughout the UN system. … The World Health Organization, for example, is very clear that the human right to health is part and parcel of their work. I guess when I hear that, it sort of raises some alarm bells in my mind about what's really going on. … Yeah, sure, you could probably improve communications, but the tools are there to do that already if people are open-minded.*[60]

Another interviewee explained that the potential of interdisciplinary collaboration depends on the individual experts involved, the issues they are working on, and the emphasis that their agencies put on mainstreaming. The interviewee explained:

> *[S]ome are more fairly open and they're sold on the issue and may even have a little bit of expertise of their own. Some are maybe obliged by a mandate to include human rights input but the extent to which that actually has a real place depends very much on how far that agency feels that they can go in featuring rights. … For some, there isn't very much space at all afforded to rights simply because there's no understanding of the relevance of rights.*[61]

Overall, the interviewees perceive that the OHCHR could be less legalistic in its interdisciplinary and inter-agency efforts to mainstream the right to health, which would facilitate collaboration with people outside the field of law.

Enhancing appreciation of the right to health across UN agencies

Many of the challenges that interviewees discussed arose in the context of the OHCHR's efforts to help other UN entities mainstream human rights into their work. While some of the challenges of inter-agency collaboration may be due to disciplinary

differences, some of them may be due to agency culture and structure. One interviewee explained:

> *Across any of our work, we find inter-agency collaboration can be very challenging in spite of all the best intentions because organizations have different demands, different pressures from different donors and different mandates and governing bodies to respond to.*[62]

OHCHR staff have counterparts—human rights officers—in other UN entities, with whom they often work to advise on mainstreaming human rights into the agency. In inter-agency efforts, OHCHR staff view their role as a collaborator. In discussing work with WHO, the United Nations Population Fund, UNAIDS, and UN Women, one interviewee explained:

> *I see it more as a collaboration than us bringing something to them. In all of these agencies, we have human rights advisors with whom we work, and we try to talk together about how we can be most constructive in whatever process that we're in, so trying to bring practical recommendations about how to present human rights in any given context.*[63]

Interviewees viewed this collaborative approach across UN entities positively. Further, as the human rights officers across agencies have a "human rights disciplinary alignment," even if their home agencies have different priorities and cultures, this facilitates communication between the organizations. As one interviewee explained:

> *I think fundamentally, it benefits both and probably is mutually supportive, because, on the one hand, it's not that easy being OHCHR and trying to carve out a permanent place or an embedded place within the larger workings of WHO, but by the same token, I can imagine it's not easy being the one rights voice sitting inside WHO trying to be heard. So it's probably helpful to have that kind of combined organizational approach.*[64]

Interviewees also noted that the OHCHR has grown considerably over the years, and its mainstreaming work has consequently grown in terms of the number of staff and the scope of work that they do. Further, interviewees noted that the OHCHR is working more on economic and social rights—including the right to health—today than it has in the past. In particular, OHCHR collaboration with WHO has been stronger in recent years, and the OHCHR is also working on health, to some extent, at the country level. Some interviewees view the closer relationship of the OHCHR with WHO as possible due to greater understanding in the health community more generally that human rights are necessary to improving health outcomes. One interviewee explained:

> *My impression is … that there's been a gradually more receptive acknowledgment and recognition within the wider health community, including the World Health Organization, that actually, if you want to improve health outcomes you can't ignore human rights. And that actually … considering human rights integrity when you're designing and delivering health strategies or health service is completely at one with delivering improved health outcomes. And I think probably, the World Health Organization, under the large global health players, had not really fully appreciated that.*[65]

While inter-agency and interdisciplinary challenges remain, most interviewees indicated that collaboration in both respects has been improving in recent years. One remaining issue for some interviewees is the tendency to self-censor when they are afraid that they may get pushback on rights issues. One interviewee reflected:

> *I wonder to what extent we allow that to calibrate the strength of our messaging. … It's a matter of trying to correctly take the temperature, to read the room a little bit so it's not always the same. With certain interlocutors you can go further, with others you're there, but you're there on sufferance. With others, your sort of input is really actively sought.*[66]

In sum, interviewees described both a lack of political will and an underappreciation of the value of a human rights approach to health as obstacles to interdisciplinary collaboration and mainstreaming the right to health across UN agencies. On the other

hand, they felt successful in supporting other human rights officers across UN agencies and perceive that human rights are gradually being accepted across agencies as necessary to improving health.

Employing health professionals at the OHCHR

Within the OHCHR, interviewees noted that public health professionals were very underrepresented on the staff. This is also a difficulty in the health and human rights field generally. Of the 20 experts we interviewed for this study, 15 have an education in law and only 3 in health or medicine. Experts in both law and health/medicine all agreed, however, that greater involvement of health professionals is necessary to operationalize the right to health. One interviewee maintained that having health professionals more involved in OHCHR policy and program decisions would make human rights more relevant to health professionals. Another interviewee explained, "Health professionals have got to grasp the right to health, and it can't just be seen as a dry, dusty legal concept. It's got to be given meaning, operational meaning. It's easier to convey that if a health professional is saying it."[67]

Interviewees expressed the view that while lawyers may have played an important role in conceptualizing the right to health, it cannot be operationalized without the full participation of health professionals. As one interviewee explained:

> *In my view we've reached a point where it's critical that health professionals are more closely involved in advocating and endeavoring to operationalize the right to health. Lawyers cannot operationalize the right to health. As I often say, if we're dependent on lawyers for operationalization of the right to health, we will all die prematurely. They can't do it.*[68]

Indeed, interviewees indicated that the absence of health professionals in efforts to mainstream the right to health on the ground prevented it from being operationalized. For some, the disciplinary barrier between lawyers and health professionals continues to make the right to health merely an aspiration or an abstraction to those in the health community. One interviewee stated:

> *There's still a long way to go before people in the health care community understand what this human rights approach actually is. ... For most of the health community, human rights is for lawyers and for idealists and maybe some politicians. This is of course wrong, and a misconception, and I think much more work has to be done on that level.*[69]

Overall, interviewees perceive that greater participation of health professionals is necessary to operationalize the right to health on the ground.

Developing deep expertise on the right to health

Interviewees remarked that considerable expertise is needed to do interdisciplinary work on the right to health. A basic understanding of the right to health is simply not adequate to have the flexibility to be able to explain the uses of the right to health in complex contexts to those not familiar with human rights. Many OHCHR staff in the field do not have that kind of expertise in the right to health. One interviewee explained:

> *There's a difference between coming to health discussions with very generic human rights messages and coming to health discussions with human rights messages which are very concrete and saying, "Well, here's the type of thing a health worker could do to help uphold human rights within the facility in which they work, and here's the type of thing that will help [that the] policy makers could do."*[70]

Similarly, another interviewee stated, "I think part of engaging in health, like any topic, is you need colleagues who build specific expertise in that area so that they can make contributions which resonate with that community."[71] As a third interviewee indicated, however, it is difficult for an employee at the OHCHR to develop substantial expertise on the right to health because most people trained in human rights do not receive much training on the right to health, and once they develop it at the OHCHR, they are then moved to another position. The interviewee explained:

> *[T]he substantive support has been weaker than ideal. That's not to say that the people who work on the [right to health] mandate aren't very competent*

> *and able individuals. They are. But it's just that when they start off in the post, they have a lot to learn because health is a big and complicated human right. And the fact that recruitment is normally through internal sort of reshuffling … and that health is sometimes quite marginal generally within the human rights family, what we tend to find is that people who don't necessarily have a background [in health] come in and they have to learn it all again from scratch.*[72]

This lack of expertise on the right to health makes it especially difficult at the country level, where substantial knowledge and experience is needed to advise in mainstreaming the right to health into policies and practices. As one interviewee noted, the backgrounds or skill sets of different country offices vary and probably reflect their previous roles at the OHCHR, which do not likely involve substantial work on the right to health.[73] Another interviewee noted that few people at the country level have any expertise in the right to health because most education programs still provide more in-depth training on civil and political rights than on economic, social, and cultural rights. A third indicated that the OHCHR is increasingly doing work on economic and social rights, and staff are therefore learning about using these rights, but "it's a learning curve."[74]

Understanding the right to health as an expanded right

Several interviewees explained that the right to health is now more often understood, at the OHCHR and beyond, to include not just health care but also the social determinants of health. One interviewee explained:

> *This idea of social and environmental determinants of health and a holistic approach on things like poverty and on discrimination, etc., being part of the determinative factors impacting health is, I think, really gaining widespread acceptance and shaping the way that health is being addressed and public health is being addressed, which in my view is a very positive thing.*[75]

This expanded understanding of the right to health makes the right to health relevant to more OHCHR staff and requires collaboration with people working in many sectors and, therefore, in many disciplines beyond health care professionals. One interviewee explained:

> *I recall that from my previous experience, we would see health as health and that's it. But my impression now when I see how many different possibilities for collaboration we have with different mechanisms and with different rapporteurs or experts, we do not have that very limited vision.*[76]

Still, one interviewee perceived that there is a need for greater appreciation of the right to health as an expanded right and its interconnections with other human rights, which would aid in operationalizing the right to health. The interviewee explained:

> *I think also it just perhaps may be an under appreciation of the role of health … I keep mentioning this, but health is an enabler of other rights. … I think, once we get to a point where there's a little bit more understanding of that, then it will enable ultimately a better sort of mainstreaming effort throughout.*[77]

In sum, while there is greater understanding today than in the past that the right to health is a broad right that involves many sectors and disciplines, there continues to be a need to mainstream these ideas throughout the UN system.

Conclusion

Our key informants perceive that to fully operationalize the right to health for all, there is a need to move beyond legal norms, to involve more health professionals in mainstreaming efforts, to promote the understanding of the right to health as a broad right that includes the social determinants of health, to enable and support the development of deep expertise on the right to health, and to enhance appreciation for the right to health across all UN agencies. Many of these efforts are underway at the OHCHR.

Our key informants indicated that the new Framework of Cooperation between the OHCHR and WHO provides opportunities to deepen col-

laboration between the two organizations and to forge closer ties between public health and human rights professionals more broadly. Increased communication and collaboration between these two communities is likely to aid in developing the expertise necessary to foster efforts to operationalize the right to health widely on the ground. Additionally, our key informants indicated that the appointment of the new High Commissioner for Human Rights—a physician with expertise in pediatrics and public health—is likely to lead to greater understanding of the indivisibility, interdependency, and interrelatedness of the right to health with all other human rights—and their relation to health outcomes. This understanding is already building within the OHCHR. Moving beyond the OHCHR and WHO, next steps will involve more constructive engagement among a wide range of professionals, disciplines, interest groups, social movements, and epistemic communities—as well as UN agencies—to make this "era of implementation" of human rights a reality.[78] Nothing less is needed to succeed in this interdisciplinary project to operationalize the right to health for all.

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References

1. J. M. Mann, L. Gostin, S. Gruskin, T. Brennan, et al., "Health and human rights," *Health and Human Rights Journal* 1/1 (1994), p. 7.

2. Ibid., p. 8.

3. Ibid.

4. UN Secretary-General, *Secretary-General's address to the Commission on Human Rights* (April 7, 2005). Available at https://www.un.org/sg/en/content/sg/statement/2005-04-07/secretary-generals-address-commission-human-rights.

5. P. Hunt, "Configuring the UN human rights system in the 'era of implementation': Mainland and archipelago," *Human Rights Quarterly* 39/3 (2017), p. 509.

6. Ibid., p. 510.

7. G. MacNaughton and M. McGill, "The Office of the High Commissioner for Human Rights: Mapping the evolution of the right to health," in B. M. Meier and L. O. Gostin (eds), *Human rights in global health: Rights-based governance for a globalizing world* (Oxford: Oxford University Press, 2018), pp. 463-485.

8. Ibid, pp. 476–480.

9. See MacNaughton and McGill (see note 7); G. MacNaughton, "Promotion and protection of the right to health by the Office of the UN High Commissioner for Human Rights," *Global Health Governance* 12/1 (2018), pp. 47–61.

10. United Nations World Conference on Human Rights: Vienna Declaration and Programme of Action, Vienna, June 14–25, 1993, UN Doc. No. A/CONF.157.24 (Part I) (1993), para. 18.

11. UN General Assembly, High Commissioner for the Promotion and Protection of All Human Rights, UN Doc. A/RES/48/141 (1993), preamble, paras. 1, 3(b), 4(a).

12. UN Secretary-General, Staffing and Functions of the Office of the High Commissioner for Human Rights and of the Centre for Human Rights, Report of the Secretary General, UN Doc. A/C.5/48/77 (1994).

13. M. Bachelet, *United Nations human rights report 2018* (Geneva: OHCHR, 2018), p. 10.

14. Z. Al Hussein, *OHCHR report 2016* (Geneva: OHCHR, 2016), p. 57.

15. Ibid., pp. 57–58.

16. Z. Al Hussein, Report of the High Commissioner on Human Rights to the Economic and Social Council, UN Doc. A/HRC/39/36 (2018).

17. Al Hussein (2016, see note 14), p. 58.

18. OHCHR, *Human rights, health and poverty reduction strategies* (Geneva: OHCHR and WHO, 2008); OHCHR, *Reproductive rights are human rights: A handbook for national human rights institutions*, (Geneva: OHCHR, UNFPA, and Danish Institute for Human Rights, 2014).

19. Z. Al Hussein, Annual Report of the United Nations High Commissioner for Human Rights, UN Doc. A/HRC/34/3 (2017); Bachelet (2018, see note 13), pp. 376, 381.

20. WHO, "UN high level meeting on universal health coverage" [press release], September 23, 2019. Available at https://www.who.int/news-room/events/detail/2019/09/23/default-calendar/un-high-level-meeting-on-universal-health-coverage.

21. Bachelet (2018, see note 13), p. 10.

22. Al Hussein (2016, see note 14), p. 59.

23. M. Bachelet, Report of the High Commissioner on Human Rights: National Policies and Human Rights:

A Compilation of Good Practices, Challenges, Lessons Learned and Recommendations in Mainstreaming Human Rights, UN Doc. A/HRC/41/21 (2019), para. 42.

24. WHO, *Leading the realization of human rights to health and through health: Report of the High-Level Working Group for Health and Human Rights of Women, Children and Adolescents* (Geneva: WHO, 2017), p. 6.

25. Ibid.; WHO, *The global strategy for women's, children's and adolescent's health (2016–2030)* (Geneva: WHO, 2015).

26. WHO (2017, see note 24), p. 12.

27. Ibid., p. 7.

28. Ibid., p. 8.

29. Ibid., p. 9.

30. Ibid.

31. Ibid., p. 8.

32. WHO, "Agreement signed between WHO and UN human rights agency to advance work on health and human rights" [press release], November 21, 2017. Available at https://www.who.int/life-course/news/who-unhcr-agreement-on-health-and-human-rights/en/; WHO and OHCHR, Framework of Cooperation between the World Health Organization and the Office of the United Nations High Commissioner for Human Rights, September 21, 2017, p. 2.

33. WHO and OHCHR (see note 32), p. 3.

34. WHO (2017, see note 24), p. 42.

35. OHCHR, *About us: Michelle Bachelet Jeria* (2019). Available at https://www.ohchr.org/EN/AboutUs/Pages/HighCommissioner.aspx.

36. M. Nissani, "Ten cheers for interdisciplinarity: The case for interdisciplinary knowledge and research," *Social Science Journal* 34/2 (1997), p. 203; B. C. K. Choi and A. W. P. Pak, "Multidisciplinarity, interdisciplinarity and transdisciplinarity in health research, services, education and policy: 1. Definitions, objectives, and evidence of effectiveness," *Clinical and Investigative Medicine* 29/6 (2006), pp. 352–353.

37. Choi and Pak (see note 36), p. 352.

38. Nissani (see note 36), p. 203.

39. Choi and Pak (see note 36), p. 355.

40. Ibid.

41. Ibid.

42. Ibid.

43. Nissani (see note 36).

44. Choi and Pak (see note 36), pp. 357–358.

45. Nissani (see note 36), p. 212.

46. Ibid.

47. Ibid., p. 213.

48. Ibid.

49. M. Freeman, *Human rights: An interdisciplinary approach*, 2nd ed. (Cambridge: Polity Press, 2014), p. 10.

50. Vienna Declaration and Programme of Action (see note 10), para. 5.

51. Ibid., paras. 10–11.

52. B. A. Andreassen, H-O. Sano, and S. McInerney-Lankford, "Human rights research method," in B. A. Andreassen, H-O. Sano, and S. McInerney-Lankford (eds), *Research methods in human rights: A handbook* (Cheltenham: Edward Elgar, 2017), p. 3.

53. Ibid.

54. See, for example, Freeman (see note 49); M. Langford, "Interdisciplinarity and multimethod research," in B. A. Andreassen, H-O. Sano, and S. McInerney-Lankford (eds), *Research methods in human rights: A handbook* (Cheltenham: Edward Elgar, 2017), pp. 161–191; E. H. Chowdhury and R. Srikanth, *Interdisciplinary approaches to human rights: History, politics, practice* (Abingdon: Routledge, 2019).

55. Interviewee #4.

56. Ibid.

57. Ibid.

58. Interviewee #14.

59. Interviewee #2.

60. Interviewee #10.

61. Interviewee #1.

62. Interviewee #18.

63. Interviewee #3.

64. Interviewee #19.

65. Ibid.

66. Interviewee #1.

67. Interviewee #12.

68. Ibid.

69. Interviewee #14.

70. Interviewee #3.

71. Ibid.

72. Interviewee #11.

73. Interviewee #19.

74. Interviewee #3.

75. Interviewee #10.

76. Interviewee # 9.

77. Interviewee #1.

78. Hunt (see note 5), p. 491.

The Universal Periodic Review: A Valuable New Procedure for the Right to Health?

JUDITH BUENO DE MESQUITA

Abstract

The right to health has been cast in increasingly broad terms in international human rights law, not only as a right to health care but also as a right to an ever more broad range of underlying and social determinants of health. Utilizing an analytical framework grounded in this broad view of the right to health, this article presents the findings of an empirical review of the right to health in the recommendations issued to states during the first two cycles of the Human Rights Council's Universal Periodic Review. The Universal Periodic Review, a peer-review mechanism, has come to occupy a prominent position in global human rights oversight, not least because all United Nations member states are regularly scrutinized under the procedure. It has also been identified as a potentially valuable mechanism to enhance accountability around the Sustainable Development Goals. The article highlights that the right to health is prominent in the Universal Periodic Review's recommendations, a conclusion that contrasts with existing perceptions that the right has been given limited attention by the procedure. However, the article argues that the quality of these recommendations is uneven. Increasing the engagement of key health stakeholders in the procedure will be important to enhance its potential for the right to health.

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Introduction

Established in 2006, the Universal Periodic Review (UPR) is one of the most ambitious recent additions to the global human rights accountability architecture of the United Nations (UN).[1] A peer-review mechanism overseen by the UN's Human Rights Council, the procedure involves a quinquennial review of the human rights record of every UN member state and culminates in recommendations issued to each state for improving its compliance with international human rights standards. Not only has the UPR come to assume a central role in global human rights oversight, but it has also been identified as having the potential to enhance state accountability around the Sustainable Development Goals (SDGs).[2]

Economic, social, and cultural (ESC) rights have become steadily more prominent in terms of the work of international human rights actors and mechanisms over the last 25 years. This is particularly true of the right to health, which has also increasingly been the focus of extensive scholarly, policy, and advocacy activity. By contrast, the right to health remains neglected by countries' laws, policies, and institutions, a situation reinforcing the importance of global oversight. Pronouncing that the UPR would be underpinned by the principles of "universality, interdependence, indivisibility and interrelatedness of all human rights," the Human Rights Council committed to balance its attention between ESC rights on the one hand and civil and political (CP) rights on the other.[3] Despite burgeoning academic and activist practice on the right to health, there has been limited attention to the UPR's record on this human right, although there have been some largely critical reviews of the procedure's record on ESC rights.[4]

This article is the first to provide an in-depth analysis of the UPR's performance on the right to health. Drawing on a comprehensive empirical review of recommendations made to states during the UPR's first and second cycles, I assess the mechanism's performance in terms of the prominence of the right to health in UPR recommendations, as well as the quality of those recommendations. Highlighting that at least 22% of first-cycle and 25% of second-cycle recommendations addressed the right to health, I argue that the right to health is prominent in UPR recommendations. However, the quality of these recommendations is uneven: they do not consistently address the right to health situation on the ground, focusing on some right to health norms and obligations while neglecting others; moreover, they are often phrased in an unspecific way that provides insufficient guidance for implementation and subsequent reviews of progress. This calls into question whether the UPR is maximizing its potential to generate improvements, as well as whether it can meaningfully enhance SDG oversight for the right to health.

The article begins with an overview of the increasing prominence of the right to health before turning its attention to the UPR, analyzing the mechanism's importance as a human rights review procedure and its potential to enhance SDG review. It also highlights existing critical research on the UPR's ESC rights record, including health. It proceeds to focus on the research methods and findings with respect to the right to health in the UPR underpinning this article. The subsequent analysis investigates apparent disparities between these findings and previous analyses in terms of the prominence of the right to health. It asserts that previous studies reflect restrictive interpretations of the right to health as much as neglect of this human right in UPR recommendations. This discussion is framed with reference to the different theoretical approaches to interpreting human rights that contribute to, and help explain, these contrasting positions. Moving on, the article sets out a framework for assessing quality, based on usefulness to the state under review and measurability, which it uses as an analytical prism to assess right to health recommendations.[5] It also analyzes the reasons why recommendations often fall short on this front, pointing to the hitherto limited engagement of health stakeholders in the UPR process as a critical factor. Increasing these stakeholders' engagement will be essential for catalyzing improvements, which are needed to support change on the ground and to better equip the UPR to support SDG review. At a practical level, this

article's findings, particularly on the prominence of the right to health in recommendations, should encourage key health stakeholders to enhance their engagement with the UPR, because one reason for their limited engagement to date is the perception that the UPR is not strongly relevant to health.[6]

The coming of age of the right to health in the UN system

Compared to the centuries-old codification of CP rights, health and other ESC rights have been recognized as legal and inalienable human rights for just over 60 years. The first international articulation of health as a fundamental human right came in the 1946 Constitution of the World Health Organization.[7] Since then, the right has been enshrined in core international human rights treaties, including the International Covenant on Economic, Social and Cultural Rights; key regional human rights treaties; and domestic constitutions, over two-thirds of which include provisions on health or health care.[8]

During the Cold War, UN oversight and implementation of health and other ESC rights was neglected compared to CP rights as a result of now-discredited, ideologically fueled assertions by Western states that ESC rights were aspirational goals and of secondary importance.[9] The end of the Cold War heralded a sea change in two ways: First, at a theoretical level, as expressed by states at the Word Conference on Human Rights, there was a new, at least ostensible, consensus that "all human rights are universal, indivisible and interdependent and interrelated. The international community must treat human rights globally in a fair and equal manner, on the same footing, and with the same emphasis."[10] Second, at an institutional level, the international community created new mechanisms to bring international oversight of ESC rights in line with hitherto superior arrangements for CP rights, including the creation of the Committee on Economic, Social and Cultural Rights to oversee the International Covenant on Economic, Social and Cultural Rights, as well as the creation of the Special Rapporteur on the right to health.[11] Burgeoning jurisprudence on health, and rights-based guidelines, reports, and projects by civil society and international organizations, have, together with this formal UN machinery, enhanced clarity about the right to health, helped improved oversight, and supported the right to health's operationalization in the work of public health organizations.[12]

These developments are lauded by some as a success story. John Harrington and Maria Stuttaford have declared that "the human right to health has moved to the center of political debate and social policy across the globe."[13] Yet progress has remained partial. ESC rights remain legally precarious, generally maintaining a "second tier" status and a smaller body of jurisprudence in domestic and international human rights legal systems, and they face enduring challenges to their status as fundamental, justiciable human rights.[14] The ESC right that is the focus of this article—the right to health—is often neglected in policy making due to policy makers' often limited awareness of it.[15] Equally problematic is the lack of a sophisticated understanding of public health and health systems among most human rights professionals. At a more profound level, the dominance of neoliberalism, which has been characterized by a rise of private providers in health care, poses both ideological and regulatory challenges for the right to health.[16] These circumstances make robust global review even more important—and the UPR, with its universal scope and influence, as well as its potential role in SDG review, is well located and equipped to play a role.

The UPR: Opportunities and challenges for human rights

The UPR is a peer-review mechanism operating under the auspices of the Human Rights Council. Its overriding objective is to "improve the human rights situation in all countries and address human rights violations wherever they occur."[17] Established as part of a broader reform package to the UN's Charter-based human rights procedures, the UPR has now undergone two full review cycles (2008–2012 and 2012–2016) and entered a third cycle in 2017. The procedure is intended to reinforce, not duplicate, the work of other international human

rights mechanisms.[18]

The UPR has been described as "one of the most important innovations of the [Human Rights Council]."[19] The procedure offers some unique opportunities for the right to health. Three principal features—the first two being undoubtedly valuable and the third of more debatable merit—differentiate it from other international review mechanisms.

First, the UPR has a universal reach. In establishing the procedure, the General Assembly noted that the UPR would review the "fulfilment by each State of its human rights obligations and commitments in a manner which ensures universality of coverage and equal treatment with respect to all States."[20] All UN member states were reviewed during the first two UPR cycles and almost all submitted their national reports for review on time. By contrast, international human rights treaties enjoy widespread, but not universal, ratification, and treaty bodies' oversight extends only to states parties. Moreover, states' periodic reports required under the treaties are often delayed or sometimes not submitted at all.[21] In other words, the UPR is valuable both in theory, because it applies to all states in a way that other human rights processes do not, and in practice, because all states take it seriously enough to subject themselves to review in a timely manner.

Second, the UPR's review of each state extends to all rights, as it is based on comprehensive protections contained in the UN Charter, the Universal Declaration of Human Rights, international treaties ratified by the state in question, and voluntary commitments and pledges.[22] This inclusive approach again contrasts with reviews by other mechanisms, which focus on selected rights (for example, the Committee on Economic, Social and Cultural Rights), situations (for example, country Special Rapporteurs), or particular groups (for example, the Committee on the Rights of the Child). A further benefit of this approach is that it allows the procedure to consider rights on the ground in a joined-up way.

These two features mirror attributes of the SDGs, which also extend to all countries and encompass wide-ranging and mutually reinforcing issues. Indeed, the SDGs share profound connections with the human rights standards that are the subject of UPR scrutiny: over 90% of SDG targets can be linked to international human rights and labor standards, and, moreover, the SDGs are formally grounded in international human rights law.[23] Recognizing these synergies, the UPR has explicitly addressed the SDGs in some of its recommendations, with many more having implicit relevance. But more than this, it has also been suggested that the UPR can support the SDGs in other ways. For example, the Human Rights Council president has suggested that it could enhance accountability in the context of the formal international SDG review procedure overseen by the High-Level Political Forum on Sustainable Development by serving as a "comprehensive source of information," and that countries could themselves use UPR outcomes when preparing their voluntary presentations for this forum.[24] This suggestion seems particularly salient in view of states' neglect of human rights issues in their voluntary national reports submitted to date for review by the forum.[25]

A third defining feature is the state-to-state peer-review format of the procedure, which is intended to cultivate a spirit of cooperation.[26] This is markedly different from other UN human rights procedures, which are carried out by independent experts. Though the UPR is meant to be conducted in an objective, non-politicized manner, its composition inherently renders it more vulnerable to politicization than these other procedures.[27] Indeed, politics have been found to affect which states give recommendations to each other; the topic and framing of recommendations; and whether states accept recommendations: this interferes with the quality and credibility of the review.[28] However, the political dimension is also seen by some as an asset. A key tenet in international relations is that states tend to listen to one another. The influences of peer pressure and a desire to earn peer respect are two suggested forces driving engagement by states in the UPR.[29] States often take reporting more seriously under the UPR than by treaty bodies.[30] It has

also been argued that UPR recommendations are more likely to give rise to follow-up, implementation, and change on the ground as a result of their being received from other states.[31]

The procedure's review process, which is to be based on objective and reliable information and take into account the specificities of the state under review, draws on three main sources of information: (1) a national report submitted by the state under review; (2) a UN report compiled by the Office of the High Commissioner for Human Rights that provides a synthesis of information on the state under review, drawing on reviews by other UN human rights mechanisms and other official UN documents, including information submitted by UN agencies; and (3) a stakeholders' report compiled by the Office of the High Commissioner for Human Rights that summarizes information provided predominantly by civil society organizations, national human rights institutions, and academics.[32] Following review, the state in question receives recommendations, which it can either "accept," thus voluntarily committing to implement, or "note," indicating no such commitment. Between cycles, states are expected to implement accepted recommendations. Implementation is formally assessed at the subsequent review of a state.

The UPR has been greeted by some as a success.[33] Others have given it a "cautious endorsement."[34] However, it has not been free of criticism. In addition to concerns about politicization, other leading concerns center on the poor quality and uneven implementation of recommendations, as well as the limited engagement of valuable stakeholders. I return to these criticisms below in the context of the right to health.

However, it is important to flag upfront critiques of the UPR for neglecting ESC rights. Drawing on a comprehensive database of UPR recommendations maintained by the civil society organization UPR Info, the Center for Economic and Social Rights has reported that only 17% of recommendations made during the first cycle exclusively addressed ESC rights, compared to 37% on CP rights, leading it to conclude that ESC rights received much less attention than CP rights.[35] Similarly, the Special Rapporteur on extreme poverty and human rights has drawn on this database to raise concerns about "both the quantity and quality of ESC rights-related recommendations."[36] The UPR Info database suggests that 2.4% of first-cycle and 3.6% of second-cycle recommendations included a focus on the right to health, ranking it 23rd out of 30 human rights issues addressed in the first cycle and 15th out of 30 in the second.[37]

By contrast, the United Nations Population Fund has found that 26.5% of first-cycle and 28.5% of second-cycle recommendations addressed sexual and reproductive health and rights and gender equality.[38] These recommendations span a range of rights, but the right to health is central to sexual and reproductive health, suggesting that it may be more prominent in recommendations than the UPR Info database suggests.

An empirical review of the right to health in the UPR: Methods and findings

Methods

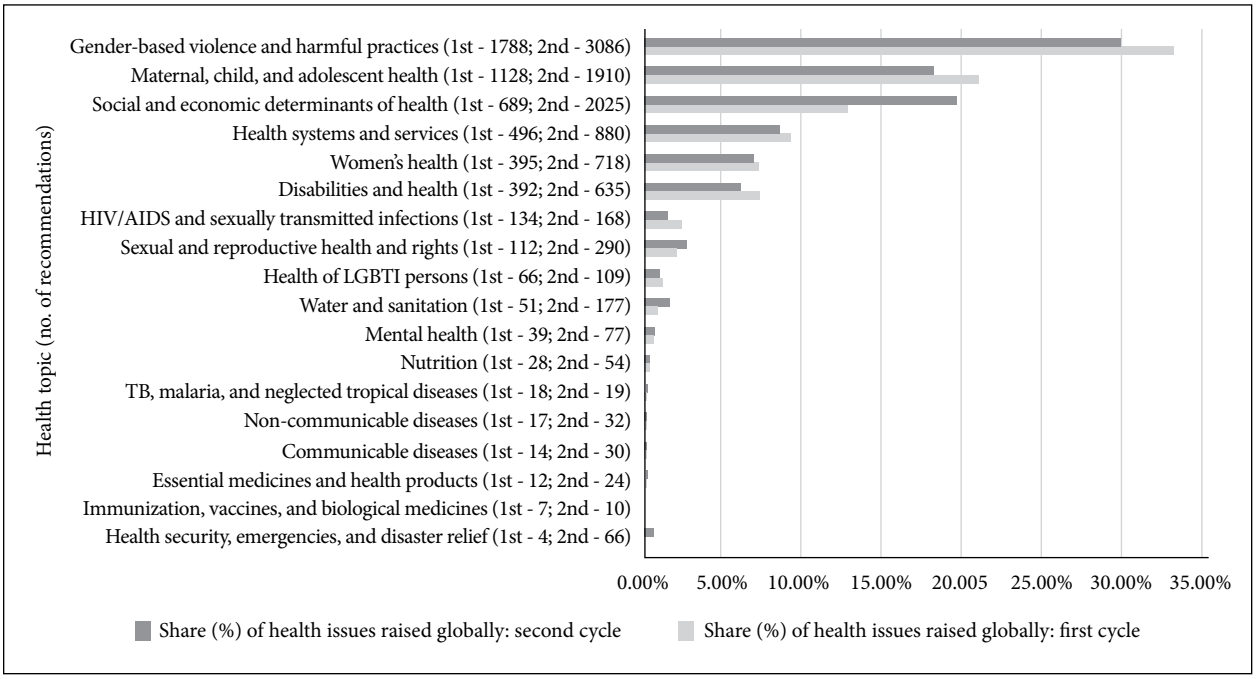
Together with the World Health Organization and the Human Rights Centre Clinic at the University of Essex, I undertook empirical quantitative and qualitative research on all recommendations made to states during the UPR's first two cycles, and in-depth case studies of recommendations received by eight countries. The research was, in the first instance, intended to support the World Health Organization in enhancing its engagement with the procedure in an informed way. The research was based on three questions: (1) How prominent was the right to health in the UPR's recommendations? (2) What was the distribution of recommendations between different right to health issues? (3) What types of actions did recommendations require? This article is based on these findings, nine in-depth interviews with staff at UN agencies and civil society organizations, and a desk review of literature on the UPR.

Before embarking on the empirical review, we carried out a detailed analysis of the parameters

of the right to health under international human rights law, as set out in international human rights treaties, such as the International Covenant on Economic, Social and Cultural Rights, and general comments on the right to health adopted by treaty bodies.[39] Utilizing this framework, we coded recommendations as right to health recommendations if they specifically referred to the "right to health," "health," or other thematic issues that fall directly within the scope of the right to health, as interpreted by these actors (see Table 1). Some recommendations addressed issues that cut across a number of human rights, such as gender-based violence: thus, what we classify as a "right to health" recommendation may also embrace other human rights. We also coded right to health recommendations by theme, according to the specific issue they addressed (see Figure 1), and by action, in terms of the type of measure required (see Table 1). Since many right to health-related terms and formulations are used in UPR recommendations, we read and coded all recommendations manually rather than by using keyword searches.

The right to health is a broad right. Two further restrictions were applied to coding right to health recommendations. First, in recent years, the right to health has been interpreted by treaty bodies to include social determinants of health, which are the social and economic conditions in which people grow, live, work, and age, as well as economic and other inequalities.[40] Orielle Solar and Alec Irwin have identified different layers of determinants, notably intermediary determinants that directly affect health outcomes, such as material conditions, the health system, biological factors, behaviors, and psychosocial circumstances; and structural determinants that operate through these intermediary determinants to affect health, such as status considerations and inequalities.[41] Recommendations that referred to an intermediary determinant addressed by treaty bodies were automatically coded as right to health recommendations; by contrast, structural determinant recommendations were coded as such only if they also mentioned the right to health or a proxy or intermediary determinant term. This position is broadly reflective of the approach of treaty bodies.[42] Second, in order to align our research more closely with the operational priorities of the World Health Organization for whom the empirical research was originally carried out, we excluded

FIGURE 1. Comparison of the proportion of paragraphs of health-related recommendations addressing each health topic during the first and second cycles of the Universal Periodic Review



a small number of intermediary determinants of health, notably torture and adequate housing, unless reference was also explicitly made to health. This may result in our findings underestimating the number of UPR right to health recommendations.

Findings

In relation to question 1, during the first cycle, at least 22% (3,862/17,638) of recommendations were right to health recommendations. This increased to at least 25% (8,356/33,956) in the second cycle. The right to health was thus a prominent issue. Both the proportion and absolute numbers of right to health recommendations increased between the cycles.

In relation to question 2, gender-based violence (33% of first-cycle recommendations; 30% of second-cycle recommendations) and maternal, child, and adolescent health (21%; 19%) were the right to health issues most frequently raised, followed by social and economic determinants of health (13%; 20%) and health systems and services (9%; 9%). There were very few recommendations on issues such as HIV/AIDS (2%; 2%), water and sanitation (1%; 2%), mental health (1%; 1%), non-communicable (0%; 0%) and communicable diseases (0%; 0%), and essential medicines (0%; 0%) (see Figure 1). There was overall consistency between the cycles in terms of the distribution of recommendations among health issues, which may be partially explained by follow-up on first-cycle recommendations during the second-cycle review.[43] Both cycles produced an uneven distribution of right to health recommendations focused on selected population groups: women, children, and persons with disabilities received many more right to health recommendations than adolescents and LGBTI persons.

In relation to question 3, the recommendations tended to require three main types of action (see Table 1). Domestic implementation measures were the predominant focus, within which there was significant attention to legislation, policies, and programs or unspecific general measures to improve the right to health, with minimal attention to national funding. This was followed by engagement with international human rights mechanisms, and then by measures relating to international cooperation obligations, which received very limited attention. At times, recommendations were not specific: they provided general advice to implement the right to health or address specific issue such as child health or gender-based violence, but without concrete guidance on what should be done or when it should be achieved.

The quantity of right to health recommendations: What can interpretive doctrines of the right to health tell us about apparent disparities in findings between this and other studies?

In contrast to previous analyses suggesting a neglect of the right to health and other ESC rights in UPR recommendations, this article argues that the right to health is actually a prominent one. The proximate cause of these seemingly divergent positions is the different interpretations of the right to health used to frame our and UPR Info's empirical reviews, the latter of which have been drawn on by the Center for Economic and Social Rights and Special Rapporteur Alston. Different interpre-

TABLE 1. Types of action required by recommendations made to states during the first and second UPR cycles

Type of action required by UPR recommendation	Cycle 1 (%)	Cycle 2 (%)
Domestic implementation obligations	70	72
• Policies, programs, and other measures	49	57
• Legislation	19	14
• National funding	1	1
International cooperation obligations	3	1
Engagement with international human rights mechanisms	27	26

tations of human rights legitimately arise because international treaty provisions are vague, with several interpretive doctrines allowing for more than one approach.[44]

Our interpretation is guided by the expansive normative scope of the right to health envisaged by international human rights treaties, one of the main sources of international law, and by the interpretations by treaty bodies, which are considered as authoritative and having significant legal weight.[45] The World Health Organization Constitution, which recognizes health as a human right, provides a broad definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[46] The International Covenant on Economic, Social and Cultural Rights' article 12 on the right to health extends beyond health care to embrace other domains such as "environmental and industrial hygiene."[47] The Convention on the Elimination of All Forms of Discrimination against Women recognizes that the right to health includes entitlements to adequate nutrition during pregnancy.[48] The Convention on the Rights of the Child includes nutritious foods, clean drinking water, environmental sanitation, and the abolition of harmful traditional practices and education on child health within its article on the right to health.[49] Finally, the Convention on the Rights of Persons with Disabilities requires states to prevent discriminatory denial of food and fluids on the basis of disability as part of its right to health article.[50] Over time, treaty bodies and others have updated interpretations of treaty protections on the right to health, taking into account changes in the world health situation and the widening of scope of the notion of health.[51] The treaty bodies have interpreted the right to health to require states to take action on issues such as safe and potable water and basic sanitation; adequate housing and safe and hygienic working conditions, an adequate supply of food, and proper nutrition; alcohol abuse, tobacco, drugs, and other harmful substances; gender-based violence; exclusion and social disparities in health; and corporal punishment.[52] These interpretations, and our findings, incorporate gender-based violence and corporal punishment—more traditionally viewed as CP rights issues of gender equality, security of the person, and the child's right to protection from violence—as parts of the right to health. Such a teleological approach is derived from the widely held understanding that human rights are dynamic and evolutionary.[53] This approach is predominant within epistemic communities in global health and human rights.

By contrast, the category of right to health recommendations in the UPR Info database utilizes meaningfully narrower parameters. The database's "Chart of Commonly Used Tags" explains that the following terms are tagged in the database's right to health category: maternal mortality, reproductive health, sexual and reproductive rights, and achievements of MDGs in the area of health.[54] Recommendations containing the term "health" or health care terms (such as "medicines" and "hospitals") are also included. Yet this excludes many social determinants. Indeed, many issues located at the intersection of the right to health and other rights are tagged in other categories—for example, nutrition is tagged as a right to food issue, while water/sanitation and HIV/AIDS are assigned their own categories. They are categorized as a right to health issue only if there is also a specific mention of health or another health-related keyword. Moreover, recommendations on right to health issues affecting particular groups are tagged according to the group rather than the right: for example, gender-based violence and abortion are tagged as women's rights issues rather than as right to health issues. This results in a far smaller tally of right to health recommendations.

These different approaches arise in the context of broader theoretical debates around interpretations of international human rights law, including the right to health. John Tobin has identified intentional, formalist, historical, systematic, teleological, and sociological approaches that can be used to interpret the right to health and that are often combined in practice.[55] Rejecting the predominant teleological approach, Tobin adopts a formalist interpretation of the right to health, which gives particular weight to the text of treaties. This is motivated by his concern with "internal sys-

tem coherence."[56] He cautions against an approach that conceives of the right to health as "a repository for everything that impacts upon the health of an individual" and which "encroaches on the normative territory of other rights."[57] Instead, he supports recognizing the connections between rights. The UPR Info database resembles this approach insofar as it categorizes recommendations according to a leading right or to a group with which a particular right has been predominantly connected in a treaty, rather than the teleological interpretation that results in ever more overlapping territory.

The debate on how overlaps between rights should be understood and how to interpret the concepts of indivisibility and inter-relatedness has yet to be settled.[58] However, given that issues such as gender-based violence, nutrition, and water and sanitation have been widely interpreted as falling within ambit of the right to health (as well as other rights), this article arguably provides an understanding of the extent of the UPR's right to health recommendations that is more attuned to how this right has evolved. At the same time, because our study focused on the right to health, its findings do not allow for a comparison with other rights: thus, it cannot be said conclusively that the right to health is not neglected compared to other rights. Likewise, our findings cannot be extrapolated to the broader category of ESC rights, so it is quite possible that this category is indeed neglected. What our findings do show conclusively is that more recommendations include a right to health focus than previously thought.

The quality of right to health recommendations: Usefulness and measurability

The quality of the UPR's recommendations is argued to be determinative of the procedure's ability to fulfill its objectives.[59] The question of what constitutes a good-quality recommendation is a contested one. I argue that a quality-assessment framework such as the one proposed by Subhas Gujadhur and Marc Limon, based on twin principles of usefulness to the state under review and measurability, is particularly valuable because it is grounded in the UPR's objectives, including improving the human rights situation on the ground.[60] Using this framework, the following paragraphs consider the quality of UPR right to health recommendations.

Turning first to the issue of usefulness, Gujadhur and Limon suggest that this is determined by the extent to which recommendations are based on an objective analysis of the main human rights challenges facing a country; are sensitive to the country's situation and available resources; and have potential to effect change. As highlighted above, the normative distribution of right to health recommendations is highly skewed, as is their attention to the types of actions that they require. This provokes the question, is this balance reflective of the right to health situation on the ground, or is it also influenced by other considerations?

Remarkably, many leading right to health problems worldwide—including deficient water and sanitation, HIV/AIDS, communicable and non-communicable diseases, and mental health—were rarely addressed in recommendations. The disproportionate focus on a small range of right to health issues suggests that the right to health situation on the ground is funneled through a selection process that decides what information is presented for review and what topics elicit recommendations.

The UPR is meant to be based on information contained in review documents.[61] A logical assumption is that recommendations reflect the right to health issues that they raise. Indeed, these reports are already known to be important determinants of recommendations.[62] To test this assumption in relation to the right to health, the Human Rights Centre Clinic and World Health Organization carried out a sample analysis of review documents from eight countries and the corresponding right to health recommendations. The review documents for these countries also demonstrated skewed attention to right to health issues. Those issues that received high levels of attention, such as gender-based violence and maternal and child health, went on to receive a high, and sometimes disproportionately high, number of recommendations, while those issues that received limited attention

received a much lower, and sometimes disproportionately low, number of recommendations.

The content of review documents is influenced by a range of factors, including, but not limited to, the human rights situation on the ground. A state's own national report, which is understood to be the most influential input into the process, is meant to be objective and reliable and prepared through a multi-stakeholder process.[63] Yet in practice, national reports often dwell on progress while glossing over obstacles.[64] Many state reports are prepared by the government, sometimes principally by the ministry of foreign affairs, with little consultation within or outside government bodies. This does little to optimize an accurate representation of the right to health situation. Likewise, in terms of the UN report, a key relevant right to health stakeholder, the World Health Organization, has had limited engagement with the UPR process at the national level.[65] Causes may include the organization's political member state structure and close working relationship with ministers of health; a lack of familiarity with human rights among its staff, who are more often public health and medical professionals; and a perception within the World Health Organization that the UPR is not effective in promoting health.[66] With regard to the stakeholders' report, which condenses submissions across the range of human rights issues into a 10-page document, there is some suggestion that information on less prominent health and rights issues has not always made the final cut.[67] Below, I suggest that increasing health-stakeholder participation is an important way to improve the spread of issues covered in review documents and subsequently the responsiveness of UPR recommendations to the situation on the ground.

The Human Rights Council's foundational UPR resolution commits to the operational principles of objectivity and non-politicization.[68] However, in practice, as highlighted above, politically uncontroversial issues are more widely raised than more sensitive ones.[69] In relation to the right to health, topics drawing recommendations from many states, such as gender-based violence, maternal health, child health, and social and economic determinants, are, in many instances, not considered sensitive. By contrast, the issue of abortion was rarely addressed. Many states have restrictive abortion laws that are defended by conservative forces in government and society to protect the fetus.[70] Yet such laws result in higher rates of unsafe abortions, maternal mortality, and other infringements of the sexual and reproductive rights of women.[71] UN treaty bodies and Special Procedures have increasingly called for progressive abortion law reform.[72] However, a keyword search of abortion and termination of pregnancy in UPR recommendations revealed that the issues were explicitly raised in just 28 recommendations (0.16% of right to health recommendations) during the first cycle, almost half of which were made to one state (Nicaragua). In the second cycle, 123 recommendations (0.36% of right to health recommendations) were made on the subject, to a bigger range of states. In both cycles, almost all of these recommendations were made by countries with progressive abortion laws, mostly from the Western European region.

Issue bias also appears to stem from the domestic and foreign policy priorities of recommending states. Gender-based violence and maternal and child health are often high on countries' health agendas, even if they are not always successfully addressed. Conversely, mental health, which attracted limited attention in recommendations, is often a deeply marginalized right to health issue.[73] This is despite an estimated one in four people worldwide being affected by a mental health condition during their lifetime.[74] At the level of individual counties, Cuba, for example, gave many recommendations focused on access to health services, a well-known national and international cooperation priority of this country, while Norway's recommendations frequently addressed issues of sexual violence, harmful practices, abortion, and LGBTI health issues, which have been high on the agenda in Norway's domestic and foreign policies.[75]

The skewed distribution between the types of actions required by recommendations also raises questions about their usefulness in terms of their responsiveness to obstacles to the right to health. Most notable is the very limited number of recom-

mendations on obligations to devote maximum available resources, particularly to the health sector, which is often deeply underfunded. Only 1% of first- and second-cycle recommendations focused on national funding. International cooperation, which includes resource and technical cooperation questions, was also rarely addressed (3% and 1% of first- and second-cycle recommendations, respectively), and almost all those recommendations suggested that states seek, rather than provide, cooperation, although both dimensions are obligations under treaties such as the International Covenant on Economic, Social and Cultural Rights. The reasons for this neglect require further research. However, two issues are perhaps relevant: first, the obligation to provide cooperation is not universally accepted by states, particularly high-income states; second, the review is meant to take into account broader resource constraints of states.[76] Obligations to provide international cooperation and national funding questions could be perceived as awkward to raise given the cooperative approach that animates the UPR.

Turning to a slightly different issue that is also relevant to quality, the UPR has been widely criticized for issuing recommendations that are non-specific, particularly concerning ESC rights.[77] A qualitative review of right to health recommendations reveals that this criticism holds true for these recommendations in two ways. First, it was not uncommon for recommendations to vaguely suggest that states should "take necessary measures" or "do more" to improve the right to health, particular health issues, or treaty implementation, without suggesting how to do so. Second, some recommendations clustered together multiple right to health or human rights issues. Both practices are questionable from the point of view of recommendations' usefulness and measurability. Recommendations that are unspecific in terms of actions required, or that cluster issues together, provide minimal guidance as to what a state's priority actions should be, thus affording overly wide discretion to the state. They are also difficult to measure for the same reason—the state can often report progress, including partial or full implementation, but it may not be clear whether these measures are moving the country as "effectively and expeditiously as possible" toward the full realization of the right to health.[78] Gujadhur and Limon have recommended that the UPR use time-bound recommendations that incorporate indicators against which progress can be measured.[79] At the same time, it is important to recognize that not all recommendations were imprecise: those focused on international human rights mechanisms and domestic legislation were often quite specific, with recommendations focused on treaty ratification, the adoption of new laws, or the amendment of existing laws.

The skewed distribution of recommendations between right to health issues and obligations, as well as the vague phrasing of many recommendations, compromises their quality and limits their potential to improve the situation on the ground. These shortcomings also raise questions about the current suitability of the UPR to support SDG review. In particular, the UPR would need to align more closely to the wider range of right to health issues and obligations that are embraced by the SDGs, which include some issues that are already more prominently addressed (for example, maternal mortality, infant mortality, and access to health services), and some issues and obligations receiving more limited attention (for example, mental health, water and sanitation, HIV, tuberculosis, malaria, neglected and other communicable diseases, non-communicable diseases, tobacco control, the health workforce, health financing, and international cooperation).

The health stakeholder gap and unlocking the UPR's potential for the right to health

Earlier in this article, I highlighted that the limited understanding of health systems and public health by the human rights community, and the limited understanding of and engagement in human rights by the public health community, pose enduring challenges to the right to health. The limited engagement in the UPR process of key health stakeholders from governments, international organizations, and civil society and the failure of the

Human Rights Council to raise a range of relevant right to health norms and obligations in an objective and informed way in recommendations, as discussed in the previous section, are emblematic of this problem.

If the UPR is to make a positive contribution to the right to health on the ground, health stakeholders must be more actively engaged in the UPR process. In some quarters, there are positive existing practices for stakeholder engagement among states, international organizations, and civil society. For example, states are being encouraged to develop national mechanisms for reporting and follow-up, one purpose of which is to enhance engagement and communication between ministries in the UPR process.[80] The UN Secretary-General has requested UN that agencies deepen their participation in the UPR, including with a view to supporting links between the UPR and the implementation of the SDGs.[81] Indeed, the World Health Organization has begun to engage with the UPR at headquarter level, even if not yet routinely at the national level.[82] Some nongovernmental organizations working on health and human rights issues have turned their advocacy efforts away from the UPR, in part because the mechanism has failed to deliver recommendations on issues of concern.[83] In other areas, notably sexual and reproductive health, civil society engagement has been more extensive, whilst the UNFPA has also engaged extensively on these issues.[84]

The involvement of health stakeholders during the lead-up to a state's review will not only provide expertise to improve the quality of information submitted but also optimize conditions for the implementation of recommendations. Although the implementation of recommendations is not the primary focus of this article, the patchy record of implementation of UPR recommendations is well documented, even if there is some suggestion that recommendations on the right to health have a better implementation record than some other rights.[85] The engagement of health stakeholders in submitting information provides a natural entry point to their engagement at a later date in supporting implementation.

Conclusion

The quantitative and qualitative research underpinning this article has provided an opportunity to reassess the performance of the UPR with respect to the right to health. Based on the empirical data, it is clear that if we understand the right to health in terms of its most widespread contemporary broad interpretation, the right is more prominently addressed by UPR recommendations than was previously understood to be the case.

While the quantity of recommendations appears to signal the value of the UPR for the right to health, this article concurs with previous more general analyses of UPR recommendations that have found the quality of recommendations to generally be poor: this is the case for the right to health too. The article has illustrated how the expert contribution of health stakeholders has been marginalized from the UPR process, notably from the review documents that are submitted for review and, at the same time, how recommendations appear to be influenced by domestic and international political agendas. The result is a spread of recommendations that does little to reflect the balance of obstacles impeding the right to health worldwide. Furthermore, recommendations often suffer from a lack of specificity. Health stakeholders' greater engagement with the UPR could help provide the level of detail needed for more specific recommendations to be issued. Not only will this support a review that reflects the right to health situation on the ground, but it will also help promote positive change through appropriately tailored recommendations and provide a more comprehensive and balanced body of recommendations to support review of the right to health in the context of SDG review procedures.

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References

1. H. Charlesworth and E. Larking, "Introduction: The regulatory power of the Universal Periodic Review," in H. Charlesworth and E. Larking (eds), *Human rights and the Universal Periodic Review: Rituals and ritualism* (Cambridge: Cambridge University Press, 2014), p. 1.
2. UN General Assembly, Res. 70/1, UN Doc. A/RES/70/1 (2015).
3. Human Rights Council, Res. 5/1, UN Doc. A/HRC/RES/5/1 (2007), para. 3(a).
4. For example, Center for Economic and Social Rights, *The Universal Periodic Review: A skewed agenda?* (New York: Center for Economic and Social Rights, 2015); P. Alston, Report of the Special Rapporteur on Extreme Poverty and Human Rights, UN Doc. A/HRC/32/31 (2016).
5. This framework was first proposed in S. Gujadhur and M. Limon, *Towards the third cycle of the Universal Periodic Review* (Versoix: Universal Rights Group, 2016), p. 18.
6. J. Bueno de Mesquita, D. Evans, and C. Fuchs, "The future of human rights accountability for global health through the Universal Periodic Review," in B. Mason Meier and L. Gostin (eds), *Human rights in global health: Rights-based governance for a globalizing world* (Oxford: Oxford University Press, 2018), pp. 545–546.
7. Constitution of the World Health Organization (1946).
8. International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI) (1966), art. 12. See also, for example, Convention on the Elimination of All Forms of Discrimination against Women, G.A. Res. 34/180 (1979); Convention on the Rights of the Child, G.A. Res. 44/25 (1989); Convention on the Rights of Persons with Disabilities, G.A. Res. 61/106 (2006); E. Kinney and B. Clark, "Provisions for health and health care in the constitutions of the countries of the world," *Cornell International Law Journal* 37/2 (2004), pp. 285–355.
9. A. Kirkup and T. Evans, "The myth of Western opposition to economic, social and cultural rights? A reply to Wheelan and Donnelly," *Human Rights Quarterly* 31/1 (2009), pp. 221–238.
10. World Conference on Human Rights, Vienna Declaration and Programme of Action, Vienna, June 14–25, 1993, UN Doc. A/CONF.157/24 (Part I) (1993), para. 5.
11. UN Commission on Human Rights, Res. 2002/31 (2002).
12. R. Thomas and V. Magar, "Mainstreaming human rights across the WHO," in B. Mason Meier and L. Gostin (eds), *Human rights in global health: Rights-based governance for a globalizing world* (Oxford: Oxford University Press, 2018); P. Hunt, "Interpreting the international right to health in a human rights-based approach to health," *Health and Human Rights Journal* 18/2 (2016), pp. 109–130; *Global health and human rights database*. Available at https://www.globalhealthrights.org/about-the-database.
13. J. Harrington and M. Stuttaford, "Introduction," in J. Harrington and M. Stuttaford (eds), *Global health and human rights: Legal and theoretical perspectives* (New York: Routledge, 2010), p. 1. See also B. Mason Meier and L. Gostin, "Introduction," in B. Mason Meier and L. Gostin (eds), *Human rights in global health: Rights-based governance for a globalizing world* (Oxford: Oxford University Press, 2018), p. 15.
14. Alston (see note 4), para. 9.
15. A. Chapman, *Global health, human rights and the challenge of neoliberal policies* (Cambridge: Cambridge University Press, 2016), ch. 1.
16. Ibid.
17. Human Rights Council, *Universal Periodic Review*. Available at https://www.ohchr.org/en/hrbodies/upr/pages/uprmain.aspx.
18. B. Mason Meier, M. de Milliano, A. Chakrabarti, et al., "Accountability for the human right to health through treaty monitoring: Human rights treaty bodies and the influence of concluding observations," *Global Public Health* 13/11 (2018), pp. 1558–1576.
19. A. Allehone, "The role and future of the Human Rights Council," in S. Sheeran and N. Rodley (eds), *Routledge handbook of international human rights law* (Abingdon: Routledge Press, 2013).
20. UN General Assembly, G.A. Res. 60/251, UN Doc. A/RES/60/251 (2006), para. 5(e).
21. OHCHR, *Human Rights Council 35th session: Opening statement by Zeid Ra'ad Al Hussein, United Nations High Commissioner for Human Rights*. Available at https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=21687&LangID=E.
22. Human Rights Council (2007, see note 3), para. 1.
23. S. Jensen, *UN human rights mechanisms proving effective SDGs monitor* (July 4, 2019). Available at https://www.openglobalrights.org/un-human-rights-mechanisms-proving-effective-sdgs-monitor; UN General Assembly (2015, see note 2), para. 18.
24. OHCHR, *Inputs from the president of the HRC to the 2016 HLPF: The work of the HRC in relation to the 2030 Agenda for Sustainable Development* (2016). Available at https://

www.ohchr.org/Documents/Issues/MDGs/Post2015/Contribution2016HLPF.pdf.

25. K. Donald and M. Ramoroka, *Five key takeaways from the 2018 High Level Political Forum* (July 30, 2018). Available at http://www.cesr.org/es/node/49690.

26. Human Rights Council (2007, see note 3), para. 3(b).

27. Ibid., para. 3; V. Carrero, "The United Nations treaty bodies and Universal Periodic Review: Advancing human rights by preventing politicization?" *Human Rights Quarterly* 39/4 (2017), pp. 943–970.

28. Carrero (see note 27).

29. W. Kalin, "Rituals and ritualism at the Universal Periodic Review: A preliminary appraisal," in H. Charlesworth and E. Larking (eds), *Human rights and the Universal Periodic Review: Rituals and ritualism* (Cambridge: Cambridge University Press, 2014), p. 38; Charlesworth and Larking (see note 1), p. 20.

30. M. Nowak, "It's time for a world court of human rights," in C. Bassiouni and W. Schabas (eds), *New challenges for the UN human rights machinery* (Antwerp: Intersentia, 2011), p. 23.

31. Gujadhur and Limon (see note 5), p. 18.

32. Human Rights Council (2007, see note 3), para. 15.

33. R. Chauville, "The Universal Periodic Review's first cycle: Successes and failures," in H. Charlesworth and E. Larking (eds), *Human rights and the Universal Periodic Review: Rituals and ritualism* (Cambridge: Cambridge University Press, 2014), p. 87.

34. Charlesworth and Larking (see note 1), p. 7.

35. Center for Economic and Social Rights (see note 4).

36. Alston (see note 4), para. 50.

37. UPR Info, *Statistics of recommendations.* Available at https://www.upr-info.org/database/statistics/index.php?cycle=1.

38. United Nations Population Fund, *Lessons from the second cycle of the Universal Periodic Review* (New York: United Nations Population Fund, 2019).

39. For example, Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, UN Doc. E/C.12/2000/4 (2000); Committee on Economic, Social and Cultural Rights, General Comment No. 22, The Right to Sexual and Reproductive Health, UN Doc. E/C.12/GC/22 (2016).

40. Commission on the Social Determinants of Health, *Closing the gap in a generation: Health equity through action on the social determinants of health* (Geneva: World Health Organization, 2008).

41. O. Solar and A. Irwin, *A conceptual framework for action on the social determinants of health*, Social Determinants of Health Discussion Paper 2 (Policy and Practice) (Geneva: World Health Organization, 2010).

42. Committee on Economic, Social and Cultural Rights (2016, see note 39), paras. 7–8.

43. Human Rights Council, Res. 16/21, UN Doc. A/HR/Res/16/21 (2011), para. 7.

44. J. Tobin, *The right to health in international law* (Oxford: Oxford University Press, 2012), p. 75.

45. M. Craven, *The International Covenant on Economic, Social and Cultural Rights: A perspective on its development* (Oxford: Clarendon, 1995), p. 91; H. Steiner and P. Alston, *International human rights in context: Law, politics, morals*, 2nd ed. (Oxford: Oxford University Press, 2000), p. 265.

46. Constitution of the World Health Organization (1946), preamble.

47. International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI) (1966), art. 12.

48. Convention on the Elimination of All Forms of Discrimination against Women, G.A. Res. 34/180 (1979), art. 12.

49. Convention on the Rights of the Child, G.A. Res. 44/25 (1989), art. 24.

50. Convention on the Rights of Persons with Disabilities, G.A. Res. 61/106 (2006), art. 25.

51. Committee on Economic, Social and Cultural Rights (2000, see note 39), para. 10.

52. Ibid; see also Committee on the Elimination of All Forms of Discrimination against Women, General Recommendation No. 24 on Women and Health (1999), para. 15; Committee on the Rights of the Child, General Comment No. 15 on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health, UN Doc. CRC/C/GC/15 (2013), para. 24.

53. S. Sheeran, "The relationship of international human rights law and general international law: a hermeneutic constraint, or pushing the boundaries?" in S. Sheeran and N. Rodley (eds), *Routledge handbook of international human rights law* (Abingdon: Routledge Press, 2013), p. 102.

54. UPR Info, *UPR Info's database* (2016). Available at https://www.upr-info.org/database/files/Database_Issues_explanation.pdf.

55. Tobin (see note 44), p. 79.

56. Ibid., p. 105.

57. Ibid., pp. 108–109.

58. A. Chapman, "The social determinants of health, health equity and human rights," *Health and Human Rights* 12/2 (2010), pp. 17–30.

59. Gujadhur and Limon (see note 5), p. 29.

60. Ibid., p. 30.

61. Human Rights Council (2007, see note 3).

62. Gujadhur and Limon (see note 5).

63. UN General Assembly (2006, see note 20); Human Rights Council (2007, see note 3), para. 15(a).

64. Gujadhur and Limon (see note 5), p. 39.

65. J. Bueno de Mesquita, R. Thomas, C. Gauter, et al., "Monitoring the sustainable development goals through human rights accountability reviews" *World Health Bulletin* 96/9 (2018), pp. 627–633.

66. B. Mason Meier and F. Kastler, "Development of

human rights through WHO," in B. Mason Meier and L. Gostin (eds), *Human rights in global health: Rights-based governance for a globalizing world* (Oxford: Oxford University Press, 2018), p. 111; Thomas and Magar (see note 12), p. 133; Bueno de Mesquita et al. (see note 6).

67. D. Lohman and J. Amon, "Evaluating a human rights-based advocacy approach to expanding access to pain medicines and palliative care: Global advocacy and case studies from India, Kenya, and Ukraine," *Health and Human Rights* 17/2 (2015), pp. 149–165.

68. Human Rights Council (2007, see note 3).

69. Carrero (see note 27), p. 958.

70. Ibid.

71. S. Singh, D. Wulf, R. Hussain, et al., *Abortion worldwide: A decade of uneven progress* (New York: Guttmacher Institute, 2009).

72. J. Fine, K. Mayall, and L. Sepulveda, "The role of international human rights norms in the liberalization of abortion laws globally," *Health and Human Rights* 19/1 (2017), pp. 69–79.

73. D. Puras, Report of the Special Rapporteur on the Right to Health, UN Doc. A/HRC/35/21 (2017).

74. World Health Organization, "Mental disorders affect one in four people" [press release], October 4, 2001. Available at https://www.who.int/whr/2001/media_centre/press_release/en.

75. See, for example, Ministry of Foreign Affairs, "Norway to increase support for women's health and safe abortion," [press release], October 12, 2017. Available at https://www.regjeringen.no/en/aktuelt/womens_health/id2574852.

76. J. Bueno de Mesquita, P. Hunt, and R. Khosla, "The human rights responsibility of international assistance and cooperation in health," in M. Gibney and S. Skogly (eds), *Universal human rights and extraterritorial obligations* (Philadelphia: University of Pennsylvania Press, 2010).

77. Center for Economic and Social Rights (see note 4), p. 6.

78. Committee on Economic, Social and Cultural Rights, General Comment No. 3, The Nature of States Parties' Obligations (1990), para. 9.

79. Gujadhur and Limon (see note 5), p. 31.

80. OHCHR, *National mechanisms for reporting and follow-up* (New York: United Nations, 2016).

81. Report of the Secretary-General on the Work of the Organization, UN Doc. A/72/1 (2016), para. 98.

82. F. Bustreo, V. Magar, R. Khosla, et al., "The future of human rights in WHO," in B. Mason Meier and L. Gostin (eds), *Human rights in global health: Rights-based governance for a globalizing world* (Oxford: Oxford University Press, 2018).

83. Lohman and Amon (see note 67).

84. United Nations Population Fund (see note 38).

85. UPR Info, *Beyond promises: The impact of the UPR on the ground* (Geneva: UPR Info, 2014), p. 28.

EDITORIAL

25 Years: Exploring the Health and Human Rights Journey

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Dedication: to founding editor Jonathan Mann and to Albina du Boisrouvray, who, as Mann wrote in his first editorial, "immediately understood, provided the means, and continues to share ideas and inspiration with us."

A true history of any movement makes for a rich, complex, and often contradictory story. Partial stories are easier to tell, and teach. Such a partial story of health and human rights might begin with crediting Jonathan Mann for starting the modern human rights and health movement 25 years ago, building upon the Constitution of the WHO, which in 1946 identified the enjoyment of the highest attainable standard of health as one of the fundamental rights of every human being. This partial story would observe definitive events including the adoption by the Committee on Economic, Social and Cultural Rights of General Comment 14 in 2000, defining the obligations that States parties have regarding the right to health at national and international levels. The story could go on to highlight certain influential conferences and groundbreaking legal cases for the right to health. It might note the ever-increasing deployment of human rights-based approaches to health and growing global recognition of the right to health. All of which would be true, but far from a whole truth.

This partial history would almost certainly draw on Mann's co-authored paper in the first issue of the *Health and Human Rights Journal* (HHRJ) in 1994, in which 'health' and 'human rights' were described as 'complementary approaches for defining and advancing human well-being'.[1] The two fields, health and human rights, the paper argued, had profound impacts upon each other, but each harbored suspicion of the other. Although the paper recognised synergies between the two fields that could advance public health, it did not quite acknowledge a 'right to health'. Our partial history would highlight how, in its formative years, 'health and human rights' discussions were predominantly disease focused, especially on HIV/AIDS, and tended to be grounded upon the impact of discrimination, especially arising from violence and other abuses of civil and political human rights. At the start of the new millennium, our simple narrative might draw on evidence to show that the use of the term 'right to health' increased in the literature and in constitutions around the globe. With Kofi Annan's declaration in 2005 of an era of human rights implementation,

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so began the operationalization of the right to health. This included the judicialization of the right to health, mainstreaming human rights in global health organizations, grassroots advocacy, and rights-based approaches to health programming.

All of which is true, but far from a whole (or only) truth.

This simplistic telling omits the details of the movement's struggles and victories and provides little guidance on how to tackle today's very real attacks on social rights, and how the tensions and synergies between distinct and overlapping fields—health and human rights—continue to be contested and evolve. A somewhat different, but complementary, history can be found in the papers published by HHRJ which has been dedicated exclusively to the health and human rights field since its first issue. Looking through our archives, we see the prescience of Mann's comment that the journal would "inform and expand the space within which ideas about the intersection between health and human rights can venture forth into the world, to be cited and criticized, debated and discussed, torn down and built up".[2]

Over the past 25 years, HHRJ has published more than 650 articles, with indeed much citing, criticizing, and debating. From the start, different understandings of the meaning of health and human rights emerged. In the first issue where Mann et al spoke of health and human rights as an intersection between two disciplines, Virginia Leary addressed 'the right to health', as one right. In her paper, Leary referred to a formative multi-disciplinary workshop on the right to health organized by the Hague Academy of International Law and the United Nations University in 1978. "It established the phrase 'right to health' within the context of international human rights and drew attention to sources of the right" (long predating our simple historical narrative).[3] Both the Mann and the Leary papers stressed the need for interdisciplinarity, with Leary calling on "collaboration among human rights scholars and practitioners, WHO, UNICEF, and public health and development experts."[4]

At the same time that Leary was calling for collaboration, the Mann paper anticipated conflict between a human rights framework (which Mann et al described as more capable at describing determinants of health) and traditional biomedical and public health approaches. In a 1995 paper, Mann writes of the "resistance" to incorporating a human rights framework which will come from within public health and that health workers would wonder about the applicability or utility, let alone necessity, of incorporating human rights perspectives into their work. As seen in the December 2019 issue, in a special section guest edited by Lawrence Gostin (one of Mann's co-authors of the 1994 paper) and Benjamin Mason Meier, papers continue to discuss the adoption of human rights within UN agencies, showing progress but acknowledging that there is no comprehensive mainstreaming of human rights. The acceptance of, and resistance to, human rights among health workers was also the focus of the special rapporteur on the right to health in his latest report to the UN General Assembly. He observes that without rights-based health education, medical hierarchies and biomedical paradigms of health are not challenged, and social determinants are downplayed. These critiques and ongoing debate around the integration of human rights frameworks in medicine and public health—resistance and acceptance—reflect the continued vibrancy and vitality (and potency) of health and human rights scholarship 25 years since the first publication of *Health and Human Rights Journal*.

While we draw a simplified history of health and human rights, we can also draw a simplified history of public health. This history, over the same time period, would almost certainly emphasize the increasing attention to social (and political) determinants of health and the critical role of inequality and racism in driving population health. Using evidence and advocacy, public health is increasingly drawing attention to the ways health is fundamentally shaped by the economy and social structures. The seeds of this focus might be found in the adoption of the Declaration of Alma Ata in 1978 by UN member states. The declaration framed the right to health as a foundational social and economic right, interrelated and dependent on other rights beyond health.

But the Alma Ata declaration could also be seen as a point of divergence between those who drew upon its call for a right to health, and advanced it with language around State obligations and accountability, and those who focused less on a 'legalistic' approach and more upon its call for a New International Economic Order. Mann could not have known how rapidly income inequality would grow or foreseen the dismantlement of the welfare states of the global north, to which so many of the newly independent nations of Africa and Asia had then aspired. Rigorous attention to income inequality has been relatively scant in the pages of the Journal, although increasing quantitative analysis of human rights and measures of income inequality (for example by the Center for Economic and Social Rights) show some attention to this field.

Looking forward, developing stronger links between a health and human rights framework and work on the social determinants of health and health equity, seems likely. In the next 25 years, we hope to work towards building and making more obvious these connections. This is aligned with Mann's vision who, writing in 1995, saw health and human rights in this broader way, offering traditional public health something it lacked—a sense of coherence and common purpose—and something heroic—a role of public health practitioners as change agents and advocates.[5]

Papers published by the Journal broadly cover legal and health research, policy, advocacy, and grassroots activism, always from a human rights perspective. Papers by health workers often reflect on the issues beyond the specific health condition being addressed, examining for example, how rights to non-discrimination, due process, privacy, freedom of expression and the right to information, impact on the attainment of health generally. While Mann was strongly associated with the fight against HIV, and the field of health and human rights has strong ties to the HIV activists who have defined a right to HIV prevention and treatment, the Journal from the beginning has published articles that seek to define or explore the relevance of human rights to multiple health related domains and issues including gender, reproductive health, disability, prisons, and clean water and the environment.

Accompanying the current issue, the journal is launching an online series of 'Viewpoints' to collate the many histories of health and human rights, to present challenges we face now, and prepare for those not yet apparent. Many of the initial commentaries have been written by contributors to the journal over the past 25 years, and we hope to see submissions from new voices, and especially health and human rights activists working in the field. While the journal has been steadfast in its focus on publishing papers that theorize and demonstrate the impact of human rights, and the right to health, we acknowledge there is much work left to be done to promote the uptake of human rights-based approaches to health, and to demonstrate the effectiveness of such approaches. It is for this reason that the Journal welcomes Jonathan Mann's other academic legacy—the Dornsife School of Public Health at Drexel University, where Mann was the founding Dean—as a publishing partner. Dornsife's focus since its inception, has been on the right to health, health equity, and research in the service of true community and policy impact. Drexel brings practical knowledge and experience and a commitment to a health and human rights approach to public health that will further enrich the Journal as it embarks on its next 25 years.

Mann and his prescient identification of the need for a strong human rights framework within public health will continue to be evident, and explored, in these pages. As always, we thank our readers, authors, reviewers, as well as human rights activists working on the frontlines, for their contribution to our common goal of seeing the right to the highest attainable standard of health realized for all.

References

1. J. M. Mann, L. Gostin, S. Gruskin, T. Brennan, Z. Lazzarini, and H. V. Fineberg, "Health and Human Rights," *Health and Human Rights Journal* 1/1 (1994), p.19.

2. Ibid, p. 1.

3. V. A. Leary, "The Right to Health in International Human Rights Law", *Health and Human Rights Journal* 1/1 (1994), p.29.

4. Ibid, p.27.
5. J. Mann, "Human Rights and the New Public Health", *Health and Human Rights Journal* 1/3 (1996), p.228.

Have Reforms Reconciled Health Rights Litigation and Priority Setting in Costa Rica?

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Abstract

The experience of Costa Rica highlights the potential for conflicts between the right to health and fair priority setting. For example, one study found that most favorable rulings by the Costa Rican constitutional court concerning claims for medications under the right to health were either for experimental treatments or for medicines that should have low priority based on health gain per unit of expenditure and severity of disease.[1] In order to better align rulings with priority setting criteria, in 2014, the court initiated a reform in its assessment of claims for medicine. This paper assesses this reform's impact on the fairness of resource allocation. It finds three apparent effects: (1) a reduction in successful claims for experimental medication, which is beneficial; (2) an increase in the success rate of medication lawsuits, which is detrimental because most claims are for extremely cost-ineffective medications; and (3) a decline in the number of claims for medicine, which is beneficial because it forestalls such low-priority spending. This paper estimates that, taking all three effects into account, the reform has had a modest net positive impact on overall resource allocation. However, it also argues that there is a need for further reforms to lower the number of claims to low-priority medicines that are granted.

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Introduction

The right to health is enshrined in supranational covenants and in more than 100 national constitutions.[2] To satisfy its demands, governments must allocate substantial resources toward meeting people's health needs. However, the right to health does not require that each person receive all necessary medical treatment, no matter what the cost. Instead, when, due to resource constraints, it is not possible to meet everyone's needs, it requires that decisions about whose health needs should be met are made fairly and accountably.[3] While there is a range of reasonable opinion on how to specify criteria for fair priority setting in detail, there is broad agreement that these should track the proper aims of the health sector, which are to increase population health and reduce inequalities in access to health services and in health-related quality of life.[4]

In many Latin American countries, it has proven challenging to establish a process for judicial decision making on claims under the right to health that is fully consistent with this imperative to set priorities fairly and accountably.[5] Costa Rica provides a case in point. While Costa Rica's Constitution does not contain an explicit right to health, the Constitutional Chamber of the Supreme Court (known as Sala IV) has derived a right to health from the right to human life (art. 21), the right to social security protection (art. 73), and international human rights treaties. This right entitles citizens to public and preventative health services as well as medical care.

In a landmark case in 1997, the court ruled in favor of the provision of antiretroviral therapy for people living with HIV/AIDS. This ruling led to an explosion of health rights litigation. The decision regarding antiretroviral therapy has been cited as an example of how litigation can redress discriminatory decisions.[6] Furthermore, later evaluation of the intervention has suggested it was consistent with fair priority setting.[7] However, subsequent cases have highlighted the potential for conflict between court decisions and reasonable priority setting. For example, in 2001, Vera Salazar Navarro challenged the Costa Rican social security institution (Caja Costarricense de Seguro Social, referred to as CCSS) for refusing to cover the branded medication she was prescribed for her multiple sclerosis. (The CCSS had offered to reimburse a less expensive generic alternative instead.) The court ruled in favor of Navarro, arguing that the CCSS had breached the patient's right to health by refusing to pay for the exact drug prescribed.[8] In this case, the court's ruling undermined effective and fair priority setting, since its decision allocated substantial resources to a use with virtually no incremental benefit. In another controversial case in 2003, the court obliged the CCSS to pay for the treatment of Gaucher disease for a young girl at an annual cost of US$160,000—equivalent at the time to 38 times the GDP per capita—for the remainder of the patient's life, overruling the CCSS's medical experts, who had judged that the cost was far out of proportion to the benefits.[9] In 2007, the court even appeared to declare explicit priority setting illegal by arguing that the CCSS could not decline treatment for "eminently economic reasons."[10]

Cases such as these are not incidental. In an important study in this journal, Ole Frithjof Norheim and Bruce Wilson classified a random sample of medication-related lawsuits filed in Costa Rica in 2008; the authors used common priority setting criteria, including size of the predicted health gain, cost-effectiveness, size of the disease burden, and the quality of evidence available for how a medication performed on these criteria. They found that 73% of successful claims were for experimental or otherwise low-priority medications.[11] This result is concerning, since it is estimated that 9% of all CCSS spending on medicines is driven by court orders.[12]

These findings lent support to complaints by the CCSS that the court's health rights decisions were harming its capacity to manage scarce resources fairly because magistrates lacked the knowledge necessary to evaluate medications. In response to this criticism, in 2014, with support from the World Bank, the court initiated a joint program with the Cochrane Collaboration (a UK-based nonprofit organization of medical experts who cooperate to produce credible and accessible

health information). Before the reform, magistrates would typically accept the evidence of the treating physician. After the reform, the court can (and in nearly three-quarters of cases does) refer the case to one of ten forensic clinics around the country, where a doctor investigates the patient's medical records, performs a physical examination, and evaluates the appropriateness of the prescribed medication using the Cochrane medical databases. (These investigations are done free of charge to the claimant. This process has made the court more reliant on evidence-based medicine.) But it is important to note that the Cochrane reviews only summarize the quality of evidence for the effectiveness of a medication; they do not include evidence on cost-effectiveness or severity of disease.

Another recent study in this journal—published by Olman Rodríguez Loaiza, Sigrid Morales Carrasco, Norheim, and Wilson—evaluates the impact of this reform.[13] They compare claims for medication post-reform (from 2016) with Norheim and Wilson's pre-reform sample (from 2008). They find that this reform has had two effects: (1) among successful claims, a shift from experimental to higher-priority medications and (2) an increase in the success rate of medication lawsuits. They tentatively conclude that the new process has led to modest gains in fairness.[14]

The data these authors have generated is of great value, especially given the paucity of information on the impacts of ways of institutionalizing the right to health in Latin America.[15] However, their analysis has three shortcomings. First, they do not establish the statistical significance of the differences they observe. Second, they miss an important potential effect of the reform, which is that it may have changed the number of medication cases brought to the court. Third, they do not provide a detailed analysis of the joint impact of the possible effects of the reform. Here, we address these shortcomings. We first analyze Rodríguez Loaiza et al.'s data and show that the two effects they identify are indeed statistically significant. We also demonstrate that the number of medication cases brought to court declined significantly post-reform. We then evaluate the joint impact of these potential effects on the assumption (which we argue is plausible) that the CCSS focuses its non-court-mandated spending on high-priority interventions. We show that if one considers only the change in the success rate and the reduction in approved claims to experimental (unproven) medications, then, contrary to Rodríguez Loaiza et al.'s judgment, post-reform health resource allocation is likely to be less fair. (This is primarily because, even post-reform, low-priority medications make up the majority of successful claims. Consequently, the increase in the success rate of claims generates a net increase in expenditure on low-priority drugs.) Furthermore, we show that if one also considers the reduction in the number of medication claims after the reform, then it is plausible that overall resource allocation is fairer post-reform. We end by suggesting that to reduce the tension between judicial decision making on individual claims and fair priority setting, the process of evaluating claims should take account of cost-effectiveness and individual disease burden.

Data analysis

In 2008, pre-reform, the Sala IV dealt with 192 claims for medications. Norheim and Wilson randomly selected 37 of the winning cases and classified them according to the effectiveness of the medicine, the severity of the condition it addresses, its cost-effectiveness, and the quality of the evidence available.[16] In 2016, post-reform, the Sala IV dealt with 128 claims for medications. Rodríguez Loaiza et al. analyzed the entire population of successful cases using the same criteria, which were operationalized in the manner explained in Table 1.

Rodríguez Loaiza et al. draw on these criteria to create an overall priority ranking into four classes: I (high priority); II (medium priority); III (low priority); and IV (experimental). They do so as follows. A medicine qualifies as high priority if and only if it scores in category I on all four criteria. It qualifies as medium priority if and only if it scores in category II on at least one criterion and in cate-

gory I or II on all other criteria. It qualifies as low priority if and only if it scores in category III on at least one criterion and in category I, II, or III on all other criteria.[17] Drugs are classified as experimental if there is insufficient evidence of effectiveness as judged by a trustworthy health technology agency.[18]

Table 2 reports Rodríguez Loaiza et al.'s findings regarding the distribution of successful cases across priority classes. (We remove from their post-reform data the five cases they could not classify, leaving 93 observations.) This explains why the percentages in Table 2 differ slightly from the ones they report. We tested whether the distribution of cases across priority classes is different before and after the reform, using a chi-square test of independence, with the null hypothesis being that the two distributions are the same and the alternative hypothesis that they are not. The *p*-value of this test is 0.046. Accordingly, we can reject the null hypothesis with a reasonable degree of confidence. (Although we use a chi-square statistic, a Fischer's exact test might be appropriate instead, since if the pre- and post-reform samples are drawn from the same population, the expected frequencies in two cells are marginally smaller than 5. Fortunately, the choice of test does not affect our conclusion, as the exact test gives a *p*-value of <0.01.[19]) The final row reports the contribution to this finding made by the shift in the share within each priority class. It reveals that the overwhelming majority of the shift is driven by the change in the share of successful cases in priority classes I (high priority) and IV (experimental). These findings support the claims made by Rodríguez Loaiza et al. about the distributional shift that has coincided with the reform.

Table 3 reports their findings regarding the success rate of all claims for medicines, supplemented by the results of our analysis. We tested Rodríguez Loaiza et al.'s claim that there was an increase in the success rate of medication lawsuits using a two-proportions Z-test, with the null hypothesis that the pre-reform litigation success rate is greater than or equal to the post-reform success rate. The *p*-value of this test is 0.0004. (Some might be concerned about the sample sizes not being very large, and argue instead for the use of a Fisher exact test. Reassuringly, the Fisher exact test gives almost identical p-values.[20]) Accordingly, we reject the null hypothesis and conclude that the post-reform success rate is indeed higher.

We now consider a further difference between pre- and post-reform data that is not discussed by Rodríguez Loaiza et al.: that the reform, by typically adding a stage to evidence gathering—a forensic doctor's report—might have affected the number (and share) of medication claims. Even though such a report comes at no direct financial cost to claimants, it involves further time and effort, including being examined by a new doctor. These represent burdens and therefore possible

TABLE 1. Rodríguez Loaiza et al.'s criteria for priority classification

Criterion	Measure	Grading
Effectiveness	QALY gain#	I > 1 QALY II < 1 & > 0.5 QALY III < 0.5 QALY
Severity of disease	QALY loss##	I > 5 QALY loss II > 1 QALY loss < 5 QALY loss III < 0.5 QALY loss
Cost-effectiveness	Cost per QALY gained	I < 1 GDP per capita II > 1 GDP per capita < 3 GDP per capita III > 3 GDP per capita
Quality of evidence	Types of published evidence	I Meta-analysis or randomized trial II Observational, non-comparative studies III Single case reports

Note: QALYs are quality-adjusted life years, a measure of health-related quality of life, in which one year in perfect health (or its equivalent) is 1, death is 0, and a year in a condition that impairs quality of life without rendering it not worth living is rated between 0 and 1, depending on the severity of impairment.
Compared to standard intervention
Compared to normal healthy life expectancy

deterrents. Moreover, the existence of this new process may have made citizens less likely to advance claims for medications of unproven effectiveness. These factors would lead one to expect a decline in claims for medication. As Table 4 reveals, this is indeed what happened. It reports the results of a two-proportions Z-test, with the null hypothesis being that the pre-reform share of medication claims is smaller than or equal to the post-reform share. The probability (p) of finding the observed proportions under this hypothesis is 0.0005. We conclude that the post-reform claims to medication are a significantly lower proportion of all cases.

Effects of the reform on resource allocation

We have found three significant differences between the pre- and post-reform situation. Of course, these differences may have causes other than the reform. But if we assume that they were due to the reform, how should we judge its impact? In this section, we answer this question. We proceed step by step, starting with the impact of the change in the distribution of accepted claims in isolation and then adding the increase in the success rate and the decrease in the number of cases brought.

If we focus on accepted claims alone, it is straightforward to see that the shift away from purely experimental drugs (class IV) documented in Table 2 leads to fairer resource allocation. One way of establishing this is to consider the cumulative distribution of accepted claims across priority classes, which is given in the "accepted claims" section of Table 5. The post-reform situation constitutes an improvement over the pre-reform situation if the post-reform cumulative distribution over priority classes ordered from I through IV is, at every point, at least as great as the pre-reform cumulative distribution, and strictly greater at some point. Table 5 reveals that the post-reform distribution is indeed an improvement in this sense.

Because fairness depends on multiple criteria (including health gain and reduction of inequality), it is more difficult to establish just how much of an improvement the post-reform distribution of accepted claims is. For simplicity, we focus on generating a rough estimate of the reform's impact on the health gain criterion.

The idea is to estimate how much total health gain is purchased for a given quantity of resourc-

TABLE 2. Distribution of successful cases across priority classes

	Share of cases in priority class (%)				p-value
	I	II	III	IV	
Pre-reform (2008, N = 37)	2.7	27.0	48.6	21.6	0.046
Post-reform (2016, N = 93)	16.1	18.3	55.9	9.7	
Contribution to chi-square statistic (%)	48.5	12.2	3.2	36.1	

TABLE 3. Success rate of litigation for the provision of medicine

Period	Number of cases	Success rate	p-value
Pre-reform (2008)	192	57.9%	0.0004
Post-reform (2016)	128	76.6%	

TABLE 4. Litigation for the provision of medicine

Period	Amparo cases (for protection of constitutional rights)	Claims for medication	Share of medication cases	p-value
Pre-reform (2008)	16,345	192	1.2%	0.0005
Post-reform (2016)	15,782	128	0.8%	

Source: Sala Constitutional de Costa Rica, Consolidado de datos generales: Estadísticas de asuntos votados por la Sala Constitucional, desglosada por año, tipo de asunto, término y tema. The 2008 data was found at https://www.poder-judicial.go.cr/salaconstitucional/index.php/2016-06-27-17-08-39/item/64-4-cantidad-de-asuntos-entrados-por-tipo-de-asuntos-ampa [accessed July 22, 2019, but the linked data was later removed; the 2008 number corresponds to 2008 data mentioned in Norheim and Wilson (see reference 1)]. The 2016 data is from https://salaconstitucional.poder-judicial.go.cr/index.php/estadisticasv1.

es that are spent in line with the pre-reform and post-reform distributions of accepted claims. To this end, we require an estimate of the gain in QALYs for each successful claim in a priority class. We used the average individual QALY gain from the data provided in Norheim and Wilson and in Rodríguez Loaiza et al., filling in some lacunae in their data. Furthermore, we required an estimate of cost per QALY gained in each priority class. We again took the averages in the data provided by Norheim and Wilson and Rodríguez Loaiza et al. (All cost-effectiveness measures were expressed in GDP per capita per QALY for the relevant base year.) Next, we required an estimate of the share of expenditure devoted to each priority class. We assumed that for each successful claim in a class, the expenditure is the estimated individual QALY gain in that class (the "quantity of health purchased") multiplied by the indicative cost per QALY in that class (the "purchase price"). Finally, we assumed that expenditure in each class is transformed into QALYs by dividing the volume of expenditure by the indicative cost per QALY for that class.

The upshot is reported in the top two rows and the "accepted claims" section of Table 6. (The calculations underlying it are in our online appendix.) It is noteworthy that the indicative cost per QALY for class III (low priority) is very high, in excess of 8 times GDP per capita per QALY, and that for class IV, it is extremely high, in excess of 32 times GDP per capita per QALY. This implies that expenditure on these medications is many times less cost-effective than expenditure on high-priority interventions. It is also noteworthy that, post-reform, the estimated expenditure shares shift principally from class IV (experimental) toward class III (low priority). To estimate the effect of this shift, we calculate the total number of QALYs generated for a given amount of expenditure on accepted claims pre- and post-reform, taking 100 times GDP per capita as an illustrative amount. The blue highlighted cells in the right-hand side of the "QALY gain" rows give the upshot: there is a marked, roughly 50% improvement in the number of QALYs gained per unit of expenditure on accepted claims. Equivalently, one can say that the estimated cost-effectiveness of expenditure on accepted claims falls from close to 9 times GDP per capita per QALY to close to 6 times GDP per capita per QALY. In this respect, the reform is a success.

However, this result of course fails to consider the impact of the increase in the acceptance rate of claims. Even post-reform, low-priority and experimental medications together make up

TABLE 5. Proportion of claims leading to spending in each priority class (%)

	Deterred	Rejected	Accepted			
Priority class	I#	I#	I	II	III	IV
Accepted						
Pre-reform			2.7	27.0	48.6	21.6
Post-reform			16.1	18.3	55.9	9.7
Cumulative pre-reform			2.7	29.7	78.4	100
Cumulative post-reform			16.1	34.4	90.3	100
Rejected and accepted						
Pre-reform		42.1	1.6	15.6	28.1	12.5
Post-reform		23.4	12.4	14.0	42.8	7.4
Cumulative pre-reform		43.7		59.3	87.4	100
Cumulative post-reform		35.8		49.8	92.6	100
Deterred, rejected, and accepted						
Pre-reform	0.0	42.1	1.6	15.6	28.1	12.5
Post-reform	31.0	16.2	8.5	9.7	29.6	5.1
Cumulative pre-reform	43.7			59.3	87.4	100
Cumulative post-reform	55.6			65.3	94.9	100

By assumption

nearly two-thirds of successful claims and, by our estimate, more than nine-tenths of the expenditure on approved claims. Consequently, the increase in the success rate of claims will lead to a corresponding increase in expenditure on low-priority and experimental medications, which may counteract the salutary effects of the reduction in the share of experimental treatments among approved claims. Further analysis is required to establish the net effect of these opposing forces.

Such analysis must rely on an assumption about the use to which the CCSS puts those resources that it is not compelled to spend on meeting successful claims. While, as in every health system, there is in Costa Rica scope for improvements in efficiency, there is also reason to assume that the CCSS generally and effectively directs resources toward improving population health and reducing health-related inequalities.[21] Expert reviews of the health system, which is to a large extent administered by the CCSS, have noted the attainment of near-universal health coverage for an extensive package of services. They also emphasize Costa Rica's excellent population health indicators (such as life expectancy and maternal mortality) in comparison with countries with a similar GDP per capita.[22] Moreover, these reviews document the health system's focus on primary care, which typically provides high-priority interventions that reach all parts of the population.[23] Public sector health resource allocation appears to be substantially pro-poor. For example, the poorest make the greatest use of public health services, and 30% of government health spending goes to the poorest 20% of the population.[24] This likely contributes to Costa Rica's comparatively low inequality in lifetime health.[25] More specifically in relation to medicines, the CCSS's Official Medicines List is drawn up by expert doctors and pharmacists in line with reasonable criteria, including efficacy, safety, the ratio of costs to benefits, impact on the financial sustainability of the system, and the ability to ensure that all segments of the population have access to these medicines and can be expected to use them as prescribed.[26] This list has been held up by the World Health Organization as an example of the optimal use of scarce resources.[27]

A recent study on the cost-effectiveness of marginal health expenditure by governments around the world supports the idea that it qualifies

TABLE 6. Indicators of cost-effectiveness, individual gain, expenditure, and overall QALY gain for claim-related expenditure

	Deterred	Rejected	Accepted				
Priority class	I	I	I	II	III	IV	Total
GDP per capita per QALY	0.5#	0.5#	0.3##	2.3##	8.2##	32.6##	
QALY gain per individual			2.4##	1.6##	1.1##	0.7##	
Accepted							
Expenditure share pre-reform (%)			0.2	9.1	41.8	49.0	100
Expenditure share post-reform (%)			1.5	7.9	62.2	28.4	100
QALY gain per 100 GDP per capita, pre-reform			0.6	4.0	5.1	1.5	11.2
QALY gain per 100 GDP per capita, post-reform			4.8	3.5	7.6	0.9	16.8
Rejected and accepted							
Expenditure share pre-reform (%)		42.1	0.1	5.3	24.2	28.4	100
Expenditure share post-reform (%)		23.4	1.1	6.0	48.1	21.4	100
QALY gain per 100 GDP per capita, pre-reform		84.2	0.4	2.3	2.9	0.9	90.7
QALY gain per 100 GDP per capita, post-reform		46.8	3.7	2.7	5.8	0.7	59.6
Deterred, rejected and accepted							
Expenditure share pre-reform (%)	0.0	42.1	0.1	5.2	24.2	28.4	100
Expenditure share post-reform (%)	31.0	16.2	0.8	4.2	32.9	15.0	100
QALY gain per 100 GDP per capita, pre-reform	0.0	84.2	0.4	2.3	2.9	0.9	90.7
QALY gain per 100 GDP per capita, post-reform	61.9	32.3	2.5	1.9	4.0	0.5	103.1

Mid-point of range for priority class specified by Norheim and Wilson
Averages drawn from data supplied by Norheim and Wilson and Rodríguez Loaiza et al. and further research

as high priority on at least one central criterion. It estimates that the cost-effectiveness of marginal health spending in middle- and high-income countries (of which Costa Rica is a member) lies between 0.18 and 0.71 of per capita GDP per QALY.[28] These assessments fall well within Rodríguez Loaiza et al.'s <1 of per capita GDP per QALY requirement for high-priority interventions.

These findings are consistent with an assumption that the CCSS focuses on interventions that fall within the high-priority category. On this assumption, and supposing that court orders do not lead to new resources being added to the CCSS budget, resources that the CCSS remains at liberty to allocate because a person's claim is rejected flow to high-priority interventions, while court-mandated spending on anything other than high-priority medications displaces high-priority spending. Some evidence of such displacement is provided by interviews with senior health officials in Costa Rica, who mention that health providers need to reallocate resources to accommodate the court's rulings.[29] Further evidence for the likelihood of such displacement comes from the CCSS's stated aim to keep spending on medicines to 8–10% of the health budget.[30] This suggests that court-mandated spending may well impair the provision of drugs on the Official Medicines List, or the expansion of this list to include new high-priority medications.

We shall therefore proceed under the assumption that ordinary CCSS spending is on high-priority interventions. For concreteness, we shall assume that expenditure on such interventions, on average, comes in at 0.5 GDP per capita per QALY (this is the mid-point of priority class I, and a reasonable estimate given the aforementioned study on the cost per QALY of marginal government expenditure on health in middle- and high-income countries; our qualitative results are, fortunately, robust to changing this assumption to a cost-effectiveness of general spending of slightly less than 3 GDP per capita). We can then, again, use our two tests to compare the fairness of pre- and post-reform claim-related expenditure. Let us start with the claim-related distributions by priority class, which are reported in the "rejected and accepted claims" section of Table 5. Clearly, the post-reform distribution does not constitute an unambiguous improvement. Indeed, the distribution associated with the pre-reform policy is superior for priority classes I and II, and only somewhat worse after that. Our first test is therefore inconclusive.

Our second test is a comparison of the benefits generated per unit of claim-related expenditure, which is reported in the "rejected and accepted claims" section of Table 6. The way to interpret it is as follows. Suppose that one sets aside 100 GDP per capita to deal with claims. If a claim is rejected, money flows toward unconstrained high-priority expenditure. If a claim is accepted, money is spent in line with the formula outlined above for accepted claims in each priority class (in proportion to both the individual QALY gain per claim and the claim's indicative cost per QALY). Because unconstrained spending is, according to our indicators, far more cost-effective than expenditure on accepted claims, the detrimental effect of the increase in the acceptance rate swamps the beneficial effect of the reduction in expenditure on experimental treatments. As revealed in the orange-highlighted cells, the upshot is a fall in QALYs generated by around one-third. We conclude that if one focuses solely on the success rate effect and the shift away from experimental treatments, then, contrary to Rodríguez Loaiza et al., on one important criterion for fair priority setting, the reform is likely to have worsened the situation.

This negative conclusion regarding the potential effects of the reform depends, however, on ignoring the reform's apparent deterrent effect on the number of claims for medication. As discussed in Table 4, compared to the pre-reform sample year, the post-reform sample year contains a reduction of around one-third in the share (and number) of writs of protection for medicines. If this reduction is due to the increased barriers to getting such a claim approved, then one must also consider the funds that the CCSS can now spend freely due to this drop. On this assumption, we again review our two indicators for the effects of the reform on resource allocation. The "deterred, rejected, and accepted claims" section of Table 5 shows that, taking deterred claims

into account, the post-reform cumulative distribution over priority classes ordered from I through IV dominates the pre-reform distribution, meaning that on this criterion, the reform represents an improvement. Our indicator for QALYs generated per expenditure of 100 times GDP per capita "set aside" for dealing with possible claims tells the same story. It is given in the green-highlighted cells in the "deterred, rejected and accepted claims" section of Table 6. These reveal that when one takes account of all three apparent effects of the reform, the reform has had a net positive effect on the criterion we have focused on, increasing the estimated number of QALYs generated for this fixed, claim-related budget by 14%. In sum, our analysis estimates that the combined effect of (1) the shift away from granted claims to experimental medicines, (2) the increase in the acceptance rate of claims to medicines, and (3) the reduction in the number of claims for medication is a moderate improvement in the fairness of overall health resource allocation. Importantly, because claims are overwhelmingly for low-priority medications even post-reform, a principal route to this likely beneficial impact is the reform's apparent deterrent effect on claims.

Limitations

While we address several lacunae in Rodríguez Loaiza et al.'s analysis, our arguments also inherit some key limitations of their data. One is that we use their priority classification, which, as they note, is only one reasonable way to classify cases. Another is that the estimates of individual QALY gain and cost-effectiveness of medicines are subject to a great deal of uncertainty. These estimates depend crucially on both the assumed comparison treatment (e.g. is the comparison "no treatment at all," or is it some alternative medication?) and the country and health system context (e.g. the estimated cost per QALY of a treatment can be much higher in, say, a private health provider in the United States than in a public provider in a middle-income country). But due to the limitations of the available literature, the studies from which our estimates are derived cannot always match the Costa Rican context. Moreover, the cost-effectiveness estimates of experimental treatments are subject to great uncertainty, because the effects of these medicines are highly uncertain. In addition, in future work on this topic based on new data, it would be better to replace our indirect estimates of the expenditure occasioned by each accepted claim with more direct observations.

A third limitation is that while we can establish statistically significant and important post- and pre-reform differences, our methods cannot establish that these differences are caused by the reform. An important avenue for further research would be to investigate the causal mechanisms behind the observed changes.

A fourth limitation is that our analysis of the joint impact of these differences relies on many assumptions and that our estimates are therefore quite uncertain. Most prominent among them is the assumption (for which we have offered indirect empirical support) that money not spent on meeting claims is spent by the CCSS on high-priority health interventions with an indicative cost of 0.5 GDP per capita per QALY. Fortunately, as mentioned above, our qualitative findings are unaffected even if we make the far weaker assumption that the cost-effectiveness of CCSS general expenditure falls just about anywhere in the high- to medium-priority range.

Finally, our quantitative analysis does not consider a different aspect of fair priority setting, which is that there must be room for effective challenge to and revision of decisions. It therefore ignores the salutary effects that a culture of frequent challenge may have on the CCSS's functioning and the legitimacy of its priority-setting process.[31] While the volume of writs of protection for health remains substantial, it is worth examining whether the new process has created undue barriers for some patients to challenge the denial of medication by the CCSS. We also note that the estimated net effect may not be permanent. If the deterrent effect on claims of the reforms was in part due to uncertainty among claimants about their chances of success under the new regime, then the number of cases might start rising again once lawyers and potential claimants notice the good post-reform prospects of success for claims to medication of proven effectiveness.

Conclusion

We have investigated whether the cooperation between the Costa Rican constitutional court and the Cochrane Collaboration has helped reconcile health rights litigation and fair priority setting. Under this reform, a person advancing a claim for medication is typically referred to an independent forensic doctor, who evaluates the appropriateness of the prescribed medication using the Cochrane medical databases. We performed a novel analysis of data provided by Rodríguez Loaiza et al. on the apparent effects of this reform. We found that the reform coincided with three substantial and statistically significant changes: (1) among successful cases, an increase in the proportion of high-priority cases and a decrease in the proportion of experimental cases; (2) an increase in the overall success rate of cases; and (3) a decrease in the number of claims for medicine. We have also analyzed these changes' joint impact. Under the assumption that the funds that are not spent on meeting court-approved claims are spent by the Costa Rican public sector on high-priority interventions, these three changes work in opposing directions. The reduction in successful claims to experimental medications represents an important improvement. Indeed, we estimate that it reduces the average cost per QALY for accepted claims by around one-third, from roughly 9 to roughly 6 times GDP per capita per QALY. However, as these numbers indicate, even post-reform, approved claims typically lead to extremely cost-ineffective spending. It follows that the increase in the acceptance rate of claims has a strongly negative effect on overall resource allocation, since it prompts more such low-priority spending. But for the same reason, the substantial drop in the number of claims to medication coinciding with the reform has been beneficial, since it permits public spending to flow toward high-priority interventions. We estimate that if ordinary public spending on health is indeed on such high-priority interventions, then the joint effect of all three changes is a moderate improvement in the fairness of overall health spending.

We conclude that the Cochrane Collaboration reform appears to have reduced the number of successful claims for unproven drugs and therefore probably represents a good first step toward reconciling fair priority setting with the right to health in Costa Rica. However, a large majority of successful claims are still for drugs that are not remotely cost-effective. It therefore seems advisable to further change the process of evaluation of such claims to take account of priority-setting criteria besides mere evidence of effectiveness, including cost-effectiveness and severity of disease.[32]

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References

1. O. F. Norheim and B. M. Wilson, "Health rights litigation and access to medicines: Priority classification of successful cases from Costa Rica's Constitutional Chamber of the Supreme Court," *Health and Human Rights* 16/2 (2014), pp. 47–61.

2. J. Heymann, A. Cassola, A. Raub, and L. Mishra, "Constitutional rights to health, public health and medical care: The status of health protections in 191 countries," *Global Public Health* 8/6 (2013), pp. 639–653.

3. See Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, UN Doc. E/C.12/2000/4 (2000), para. 19; A. Voorhoeve, T. T.-T. Edejer, L. Kapiriri, et al., "Three case studies in making fair choices on the path to universal health coverage," *Health and Human Rights* 18/2 (2016), pp. 11–22; B. Rumbold, R. Baker, O. Ferraz, et al., "Universal health coverage, priority setting, and the human right to health," *Lancet* 390/10095 (2017), pp. 712–714; D. W. L. Wang, "Courts and health care rationing: the case of the Brazilian Federal Supreme Court," *Health Economics, Policy and Law* 8/1 (2013), pp. 75—93.

4. World Health Organization, *Making fair choices on the path to universal health coverage: Final report of the Consultative Committee on Equity and Universal Health Coverage* (Geneva: World Health Organization, 2014); see also A. Voorhoeve, "Why health-related inequalities matter and which ones do," in O. F. Norheim, E. J. Emanuel, and J. Millum (eds), *Global health priority-setting: Beyond cost-effectiveness* (Oxford: Oxford University Press, 2020).

5. See, e.g., O. L. M. Ferraz, "The right to health in the courts of Brazil: Worsening health inequities?" *Health and Human Rights* 11 (2009), pp. 33–45; D. W. L. Wang, "Courts and health care rationing: The case of the Brazilian Federal Supreme Court," *Health Economics, Policy and Law* 8 (2013), pp. 75–93; L. Reveiz, E. Chapman, R. Torres, et al., "Litigios por derecho a la salud en tres países de América Latina: Revisión sistemática de la literatura," *Revista Panamericana de Salud Pública* 33 (2013), pp. 213–222; R. Dittrich, L. Cubillos, L. Gostin, et al., "The international right to health: What does it mean in legal practice and how can it affect priority setting for universal health coverage?" *Health Systems and Reform* 2/1 (2016), pp. 23–31; Rumbold et al. (see note 3).

6. H. V. Hogerzeil, M. Samson, J. V. Casanovas, and L. Rahmani-Ocora, "Is access to essential medicines as part of the fulfilment of the right to health enforceable through the courts?" *Lancet* 368 (2006), p. 310; L. Cubillos, M.-L. Escobar, S. Pavlovic, and R. Iunes, "Universal health coverage and litigation in Latin America," *Journal of Health Organization and Management* 26/3 (2012), p. 401.

7. O. F. Norheim and S. Gloppen, "Litigating for medicines: How can we assess impact on health outcomes?" In A. E. Yamin and S. Gloppen (eds), *Litigating health rights: Can courts bring more justice to health?* (Cambridge, MA: Harvard University Press, 2011), p. 314, table 12.1.

8. R. Dittrich, "Healthcare priority setting in the courts: A reflection on decision-making when healthcare priority setting is brought to court," *F1000Research* 6 (2017).

9. S. Heuser, "One girl's hope, a nation's dilemma," *Boston Globe* (June 14 2009). Available at http://archive.boston.com/news/world/latinamerica/articles/2009/06/14/one_girls_hope_a_nations_dilemma.

10. Sala Constitutional de Costa Rica, Resolution number 2007-00043. See also resolution numbers 2002-7384, 2005-13408, and 2008-0907, among others.

11. Norheim and Wilson (see note 1).

12. R. Piza, *El sistema nacional de salud: El caso de Costa Rica*, Encontro Internacional Dereito a Saude, Cobertura Universal e Integralidade Possível, Belo Horizonte, 2016, cited in Organization for Economic Cooperation and Development (OECD), *Reviews of health systems: Costa Rica 2017* (Paris: OECD, 2017), p. 76.

13. O. Rodríguez Loaiza, S. Morales, O. F. Norheim, and B. M. Wilson, "Revisiting health rights litigation and access to medications in Costa Rica: Preliminary evidence from the Cochrane Collaboration Reform," *Health and Human Rights* 20/1 (2018), pp. 79–91.

14. Ibid.

15. A. E. Yamin, A. Pichon-Riviere, and P. Bergallo, "Unique challenges for health equity in Latin America: Situating the roles of priority-setting and judicial enforcement," *International Journal for Equity in Health* 18/106 (2019); O. Maestad, L. Rakner, and O. L. M. Ferraz, "Assessing the impact of health rights litigation: A comparative analysis of Argentina, Brazil, Colombia, Costa Rica, India and South Africa," in A. E. Yamin and S. Gloppen (eds), *Litigating health rights: Can courts bring more justice to health?* (Cambridge, MA: Harvard University Press, 2011).

16. Norheim and Wilson (see note 1).

17. Ibid., p. 58.

18. Ibid., p. 52.

19. We thank Arnaldur Stefansson for this observation.

20. We thank Arnaldur Stefansson for this observation.

21. See OECD (see note 12), p. 31.

22. J. Cercone and J. Pacheco Jiménez, "Costa Rica: Good practice in expanding health care coverage," in P. Gottret, G. J. Scheiber, and H. Waters (eds), *Good practices in health financing: Lessons from reforms in low- and middle-income countries* (Washington, DC: World Bank, 2008), p. 183; see also B. M. Wilson, "Costa Rica: Health rights litigation; Causes and consequences," in A. E. Yamin and S. Gloppen (eds), *Litigating health rights: Can courts bring more justice to health?* (Cambridge, MA: Harvard University Press, 2011).

23. Cercone and Pacheco (see note 22), p. 194; OECD (see note 12), p. 20.

24. Cercone and Pacheco (see note 22), figures 8.3, 8.4.

25. O. F. Norheim and S. Gloppen (see note 7), table 12.1.

26. Pan-American Health Organization (PAHO), *Access to high-cost medicines in the Americas: Situation, challenges and perspectives*, Technical Series No. 1 (Washington, DC: PAHO, 2010).

27. World Health Organization, "Rationalizing drug use in Costa Rica," *Essential Drugs Monitor* 8 (1989), p. 14.

28. B. Woods, P. Revill, M. Sculpher, and K. Claxton, "Country-level cost-effectiveness thresholds: Initial estimates and the need for further research," *Value in Health* 19/8 (2016), table 1.

29. Heuser (see note 9); Maestad et al. (see note 15), p. 292.

30. PAHO (see note 26), p. 67.

31. For one study that argues that judicialization can have such salutary effects, see J. Biehl, M. P. Socal, and J. J. Amon, "The judicialization of health and the quest for state accountability: Evidence from 1,262 lawsuits for access to medicines in southern Brazil," *Health and Human Rights* 18/1 (2016), pp. 209–220.

32. See also Rodríguez Loaiza et al. (see note 13); OECD (see note 12), pp. 31, 76.

"Hay que tener suerte": Gender-based Violence Service Provision in Quito, Ecuador

CHIARA SABINA AND DIEGO PÉREZ FIGUEROA

Abstract

This study utilized the United Nations' *Essential Services Package for Women and Girls Subject to Violence*, a technical guidebook on quality services in line with human rights declarations, to examine the characteristics of availability, accessibility, adaptability, and appropriateness from the viewpoint of 21 victim service users in Quito, Ecuador. Availability was evidenced by warm service providers willing to aid victims but was hindered by a failure to make available all desired services (such as those related to economic empowerment). Accessibility was aided by service locations that were easily accessible and by referrals, but a lack of information and conflicting schedules thwarted users' help-seeking efforts. Participants shared experiences of services adapted to their specific needs and experiences of violence, but additional services were needed to fully attend to their particular circumstances. Participants shared how service providers empowered them by listening to their experiences and helping them move forward in their lives. Nonetheless, participants shared experiences of victim-blaming and other harmful attitudes from providers. Overall, there was a great amount of variability in participants' service experiences. Areas for consideration include economic empowerment, expansion of services to men and children, increased access to information, and trauma-informed training of staff in order to better respond to gender-based violence.

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Introduction

The Universal Declaration of Human Rights of 1948 states both that "no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment" and that "everyone has the right to a standard of living adequate for the health and well-being of [themselves] and of [their] family."[1] Nonetheless, the bridging of the two human rights—protection from violence, specifically violence against women, and the right to health—remained elusive until the mid-1990s. Framing violence against women as a human rights violation is an important step in formally labeling this type of violence as unjust and socially wrong, with attached duties and responsibilities for accountability at the individual and state levels.[2] It was not until the Declaration on the Elimination of Violence against Women and the Convention of Belém do Pará that violence against women was defined as a violation of human rights at the international level and freedoms and duties of states were delineated.[3] These documents specified the desired outcome for services but did not indicate what specific services were needed nor how these services should be delivered. Our study uses recent multiagency guidance from the United Nations Joint Global Programme on Essential Services for Women and Girls Subject to Violence to examine gender-based violence services in the Ecuadorian capital of Quito.[4]

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) was a significant advancement that recognized the confluence of violence, health, and human rights in the lives of women.[5] In 1992, the CEDAW Committee—which monitors states' compliance with the convention—issued General Recommendation No. 19 on violence against women, stating that "gender-based violence is a form of discrimination that seriously inhibits women's ability to enjoy rights and freedoms on a basis of equality with men" and "states parties should establish or support services for victims of family violence, rape, sex assault and other forms of gender-based violence."[6] In 1993, the Declaration on the Elimination of Violence against Women, issued by the United Nations General Assembly, explicitly focused on physical, sexual, and psychological family violence; community violence; and state violence.[7] The following year, the Convention of Belém do Pará affirmed that "violence against women constitutes a violation of their human rights and fundamental freedoms, and impairs or nullifies the observance, enjoyment and exercise of such rights and freedoms" and called on states to condemn all forms of violence against women and respond appropriately through legislation, specialized services, and assessment of efforts.[8]

Women's movements across Latin America have fought for the end of gender-based violence since the beginning of the 1970s and sought more recognition of gender-based violence as well as legal and service advancements.[9] Ecuador ratified CEDAW in 1981, and, in 1995, shortly after the signing of the Convention of Belém do Pará, passed a law on violence against women and families that seeks to prevent violence and offer protection for victims (Law 103).[10] Article 66 of Ecuador's Constitution also acknowledges the right to live free from public and private violence and declares that "the state shall adopt the measures needed to prevent, eliminate, and punish all forms of violence, especially violence against women, children and adolescents," further providing the vision for a human rights-based approach to violence prevention.[11] Services are delineated in articles 35 and 78, which refer to specialized services, restitution, compensation, rehabilitation, and victim assistance.[12] In addition, the main legal framework in Ecuador, the Organic Integral Penal Code, penalizes gender-based violence in a series of misdemeanors and crimes.[13] This is further buttressed by a national plan to end gender-based violence, which acknowledges the individual, social, and economic costs of gender-based violence and sets out an intersectional model to, among other goals, create specialized services, avoid revictimization, train professionals, and facilitate collaboration among service providers.[14]

Nevertheless, violence against women remains high and access to quality services remains difficult. In Ecuador, a recent national survey of 18,880 women over the age of 15 revealed that about 49% had experienced partner violence in their lifetime.[15]

The forms of violence experienced include psychological (43.4%), physical (35.0%), sexual (14.5%), and patrimonial violence (10.7%). The health impact of violence against women is undeniable. Violence against women damages women's physical, mental, sexual, and reproductive health while also increasing morbidity and mortality.[16]

The *Essential Services Package for Women and Girls Subject to Violence*, written by the United Nations Joint Global Programme on Essential Services for Women and Girls Subject to Violence, identifies the essential services that the health care, social service, police, and justice sectors should provide for women and girls who suffer violence.[17] The framework outlined by the *Essential Services Package* is in line with human rights declarations and includes key principles (for example, a rights-based approach and perpetrator accountability), common characteristics (for example, appropriateness, informed consent, and confidentiality), essential services and actions, guidelines for national-local coordination (for example, in the areas of law and policymaking), and foundational elements (for example, training and workforce development). The need for the *Essential Services Package* arises from the enduring effects of violence and the demand for a coordinated set of quality services equipped to respond to various forms of violence. While all of these elements are necessary for an effective response to violence against women, we chose four common characteristics on which to focus our study: availability, accessibility, adaptability, and appropriateness. These elements should be readily observable by service users and build on a long line of work related to health care access.[18] However, the recent application of these characteristics to gender-based violence services in low- and middle-income countries, as done in the *Essential Services Package*, allows for a more tailored and context-sensitive application of these characteristics. Given the coverage and specificity of this model, we believe it provides a hitherto unexplored way of studying these issues.

The essential package underscores the need for services to be readily available to all in sufficient quality and quantity. Services should be available to all populations and sectors, without geographic or social discrimination. With regard to quantity, it is clear that most governmental and nongovernmental services in Quito are concentrated in the center and center-north areas of the city, while they are in very short supply in other areas.[19] Governmental services, although more evenly distributed (with at least one specialized court per administrative zone), are very scarce in some areas, which underlines the need for the participation and aid from local nongovernmental organizations (NGOs) to broaden service coverage for women, especially marginalized women.[20] However, even with NGOs' help, a large part of the population still has low access to services.[21] In Quito, there exists only one medical unit specialized in intimate partner violence and sexual violence and only one battered women's shelter, which has a 10-women capacity.[22] Services are often in high demand, revealing the need for more personnel.[23] Thus, looking at the basic requirement that services be available, there appears to be a lack of availability in Quito.

A call for higher-quality services has been present in publications as early as 1999.[24] In Ecuador, the "Critical Path" study funded by the World Health Organization identified sociocultural perceptions of violence as the main limitation to quality services. The majority of service providers in that study were found to favor the family unit over the integrity of the victim.[25] Moreover, they found that justice and policing services were practiced unevenly, were heavily bureaucratized, and favored individual connections over institutional connections.[26] This results in an irregular quality of services due to a lack of sensitive and qualified personnel, which in turn leads to an underestimation of the issue, long and inefficient processes, and victim-blaming.[27]

Accessibility centers on the idea that services should be geographically, economically, and linguistically accessible to all women. The most common identified barriers for accessibility are economic barriers and the lack of knowledge about the procedures. Though services are stipulated as free in Ecuador, in most cases there are hidden costs such as transportation, legal fees, and doc-

ument photocopies for legal services.[28] A study that focused on five Ecuadorian NGOs found that there is general ignorance about the functioning of the legal system, its jurisdiction, the rights of victims, and legal responsibility and obligations of the service institutions by service providers.[29] Additionally, most services are not adapted for disabilities, and not all disabilities are contemplated.[30]

Adaptability calls attention to the fact that violence does not affect all women in the same way, and different needs require different service approaches. Thus, essential services should adapt to users' demands and must be equipped to understand the different situations of violence women might find themselves in. The "Critical Path" study found that service providers generalized across victims, thus precluding a response adapted to each victim's particular circumstances.[31] This lack of understanding is also exacerbated by ignorance of the particularities of different ethnic groups.[32] But, by far, the most complex and prevalent problem is the lack of adaptability in the speed of procedures and the hidden economic barriers, which are not subsidized for women with a lower economic status.[33]

For essential services to be appropriate, they must respect the victim's dignity, avoid any secondary victimization, and respect her decisions regarding the services she wishes to use, as well as provide options to empower her and address her needs, preserve confidentiality, and promote autonomy. According to the Ecuadorian Constitution (art. 76), victims have rights to due process; and according to the Integral Organic Penal Code (art. 1), essential services must respect dignity, allow autonomy, and abstain from any practice that might cause secondary victimization.[34] Nevertheless, reality is another matter: essential services personnel do not necessarily know or apply the law.[35] A lack of training and adequate funding leads to legal, medical, and psychological services without scientific rigor and service providers that harbor sexist perceptions and beliefs prioritizing familial stability over women's safety.[36] Some studies have reported just plain rude and unqualified service operators who revictimize and do not empower victims.[37] Thus, from the available research, it seems that while these qualities are advanced in the letter of policies, practice has not followed suit.

Overall, most research on the provision of quality services is not recent or generally informed by service providers. During Ecuador's latest political period, many aid agencies and NGOs left or closed, leaving mostly state-funded research and programs.[38] Thus, there is a clear need to examine these qualities from the perspective of service users. Our study assumes this task via a series of focus groups with women who have accessed victim services in Quito.

Method

Procedure

In order to understand the availability, accessibility, adaptability, and appropriateness of services from the perspective of victims, we conducted three semi-structured focus groups with users of victim services in May 2016. After we built relationships with victim service organizations, three of them consented to allow us to hold focus groups with their users. Only users that have been engaged with services and were not in crisis were recruited. Each organization handled its own recruitment efforts as best suited to its style. Generally, staff personally invited users to participate. Each focus group took place at the site of the organization at a time deemed suitable by the participants. The three organizations were (1) a nonprofit domestic violence service provider ($n = 12$), (2) a city organization that provides counseling and legal assistance ($n = 3$), and (3) a city-supported organization that provides counseling and legal assistance ($n = 6$). All organizations were in Quito, Ecuador. Focus groups were conducted, transcribed, and analyzed in Spanish by the primary author and collaborators. Quotations for this manuscript were translated by two bilingual researchers. All focus group participants were informed about the study and the nature of the questions before beginning the focus groups. Each woman provided her verbal informed consent to participate. Focus groups lasted between one and a half and two hours each. Women were compensated either with US$5 or a lunch equivalent to

US$5. Three institutional review boards approved this work—one in the United States and two in Ecuador.

Participants

Demographic information is available in Table 1. The sample was racially/ethnically homogenous, with 100% of those responding indicating they identified as mestiza (which translates to mixed race, especially referring to European and indigenous). The average age of the sample was 38 years old. The majority of the sample was employed (63.2%), and more than half had a high school education (secondary school) or above (52.6%). Aggressors were primarily husbands (42.1%), and abusive relationships tended to last 10 years or more (55.6%). About a third of the women were still in a relationship with the aggressor (35.3%), and 68.4% had experienced self-defined violence within the last year. On average, the sample was engaged with services for 5.82 months, although this ranged from zero months (new client) to two years of services. One of the focus groups consisted primarily of refugees from Colombia.

Measures

Focus group protocol. The focus groups began by asking participants to describe their decision to seek services, then centered on participants' perceptions of the four main characteristics (availability, accessibility, adaptability, and appropriateness) of services, and closed by asking about participants' satisfaction with services and recommendations for improvement. The semi-structured format probed the *Essential Services Package* characteristics (availability, accessibility, adaptability, and appropriateness) by explaining each attribute and asking participants about their experiences with each. Questions and probes were altered and added as needed to understand experiences with and impressions of victim services. All of the groups also explored participants' prior experiences with victim services, particularly criminal justice services.

Questionnaire. At the end of each session, we asked participants to complete a demographic questionnaire. Questions asked about ethnic/racial identification, work status, educational attainment, relationship with abuser, last violent episode, and when services were sought. Responses relied on participants' own interpretations of violence and their own recollection of events.

Data analysis

Transcripts were reviewed by three research team members, and segments reflecting the categories (availability, accessibility, adaptability, and appropriateness) were coded as such. Each theme was further subdivided into positive and negative examples. Accounts of previous services were also coded but kept separate from experiences with the focal service providers. Thus, an a priori (deductive) coding method was used based on the *Essential Services Package*.[39] Codes were applied by two research team members, reviewed by the primary author, and then discussed and recoded to ensure conceptual and definitional consistency by two research team members. At the end of the process, there was 100% agreement on the codes applied to the data. Codes were then entered into NVivo.

Results

Availability relates to services being available in sufficient quantity and quality without any form of discrimination. Positive aspects of service quality that participants identified include being organized, being professional, offering appointments quickly, valuing users, and being warm to users. Participants also reported being pleased with workshops and particular staff members:

> *You notice she [the staff member] has more charisma just by seeing her, without taking into account her professional degree. … The other one didn't even offer a breathing exercise, not even a glass of water. At least the one from here she impressed me, I swear she impressed me, she got up and brought me a cup of tea.*

In terms of services that were not available, women indicated that they would like to see services for youth in schools, support for couples, services

TABLE 1. Participants' demographic information

Attribute	Number (N=19)	%
Race/ethnicity		
Mestiza	17*	100
Employment		
Worked last week	11	57.9
Didn't work last week but had job	1	5.3
Looking for work for the first time	2	10.5
Looking for work and worked before	2	10.5
Student	1	5.3
Housewife	2	10.5
Education		
None	1	5.3
Did not finish primary school	3	15.8
Finished primary school	1	5.3
Did not finish secondary school	4	21.1
Finished secondary school	5	26.3
Did not finish college	3	15.8
Finished college	2	10.5
Relationship to aggressor		
Married	8	42.1
Separated	2	10.5
Civil union	3	15.8
Family member	3	15.8
Unrelated/armed conflict	3	15.8
In current relationship with aggressor?		
Yes	6	35.3
No	11	64.7
Length of relationship with aggressor		
6–11 months	1	5.6
3 years	1	5.6
5 years	1	5.6
6 years	1	5.6
8 years	1	5.6
9 years	1	5.6
10 years	2	11.1
More than 10 years	10	55.6
Length of time since violence occurred		
There is currently violence	3	15.8
2–3 weeks	1	5.3
2–3 months	3	15.8
4–5 months	2	10.5
6–7 months	3	15.8
8–9 months	1	5.3
One year	2	10.5
More than one year	4	21.1
	Mean	Standard deviation
Age in years	38.00	9.71
Length of service engagement in months	5.82	6.84

* Only 17 of the 19 respondents answered this question.

for children (including day care), prevention and awareness, microenterprise support, and services for men. Participants' support for services for men was based on two arguments: (1) men also suffer from violence and (2) helping abusive men heal their wounds would in turn help women. One participant said, "Then it would be good if at some time they do workshops with them, not always, but it would be good if every so often they did it. That would also help them realize how much the partner of that person affects the woman." Many women mentioned microenterprise and economic empowerment as a way to escape violence. Participants advocated for workshops, skills training, and other types of support to start small businesses, such as crafts and baking:

> *Although perhaps I think that the change would be from us, like the girl over there says. It would be to prepare us to be able to go out and support ourselves between all women, have perhaps a connection to someone who can teach us about entrepreneurship. For example, we could make a plan and help each other out and make an idea, a microenterprise, no? Then we would not suffer economically, we would stop trying to see if we sell or not, we would have some income, but all united as women, well that's my suggestion.*

Accessibility centers on the ability to access services without barriers, including physical, economic, and linguistic ones. Women's access to services was fostered by locations that were close to their homes, transportation routes, or jobs; referrals from other service providers and friends and relatives; an ample and flexible schedule for attending to users; and websites describing services. Barriers that limited their access to services included those identified in the *Essential Services Package*, such as economic accessibility (for example, the inability to pay a psychologist or purchase medication). Some participants also mentioned how work and child care obligations limited their ability to access services. The difficulty in this situation of finding available appointment times reflects some of the administrative barriers to services. However, the most common barrier identified by focus group participants was a lack of information. This included not knowing that the services existed or how to access them, not knowing what other services were available, and not understanding how appointments were made:

> *I think that there should be more publicity, because there are so many of us who need this process to help ourselves. There are some people who don't receive this process because they don't [file a police] report, it's because of that that you are sent here, that's why you know about it. Many people don't know about this place.*

Adaptability includes recognition of the differentiated impacts of violence according to each individual's particular circumstances. In other words, it allows for different options within services to best meet users' unique needs. Focus group participants talked about service providers listening to them and helping them clarify their situations, which was a form of individualized attention. Specific circumstances to which service providers were responsive include recognizing a woman's co-dependent relationship with her son; addressing aggressive behavior on the part of a woman; helping women improve their economic stability through skills training; incorporating spiritual aspects into psychological treatment; treating children; offering psychiatric services; teaching life skills such as cooking; and supporting well-being through yoga classes. Service providers also tailored services by assisting with cases of physical abuse, sexual abuse, psychological abuse, and/or child maltreatment. Further, some participants spoke about their children and their partners also receiving services, which allowed them to feel hopeful about ending violence in their families:

> *So, then I searched for help. I know that they will help us here, with individual therapy, group therapy. It has already cleared my mind and has helped me a lot. In couples therapy, we've said everything, like he said his things and I said my things. I said everything that I felt because of all he has done to me. We said everything. I don't know, it was like a relief, and I feel very good.*

Negative adaptability generally centered on services that participants needed but that were not available

at a particular service site, such as child psychologists, services for men, medical services, and legal aid. Participants commonly mentioned their desire to start a small business or learn skills in order to increase their economic productivity. "Of course it would be good, here we are women who are fighters who want to establish our own businesses."

Services that are appropriate are delivered in ways that maintain users' dignity and confidentiality, while minimizing secondary victimization. Service users should feel that services are agreeable to them and empower them. Participants talked freely about what they gained from services—a sense of self, confidence, support, and encouragement, all in line with appropriateness:

> *I learned to hug, I learned about everything, everything changed for me, even people who knew me told me that now that I am 42 years old, they see me looking better than when I was 20. Yes, and that encourages me. It's difficult, but yes I learned a lot. I mean, I learned in one year what I didn't learn in 40 years—to love myself, to accept myself as a woman.*

But when you feel the need to pull out what you have inside and tell it to people, like the psychologist, like in my case they have listened to me. And to me, that's very important—to be heard and not necessarily be given something. I know that you need stuff, but I believe that in one of these houses it's important that they listen to you, that you can release the pain you have inside, and you can start to love yourself and respect yourself more, and to me that's the most important thing.

One participant spoke about feeling trapped in the shelter with little attention to her particular needs and desires. For example, serving meat, but no eggs, to a vegetarian and shutting off the hot water early in the morning. Another stated that her wounds are so deep that no amount of psychological treatment would be able to heal them. Other issues that affected the appropriateness of services include staff turnover and feeling cut off from family members.

During the course of the focus groups, participants also shared their experiences with other service providers, which ranged from helpful to endangering. Positive experiences with other service providers mirrored some of the positive experiences with current services; however, women were generally more restrained in their praises. A few participants indicated that other service providers had been helpful and had taken them seriously. With regard to the criminal justice system in particular, one participant commented that her case did not take a long time (three to four months), and another felt understood by the judge and was pleased that instead of arresting her partner, the court ordered him to undergo counseling.

On the whole, however, women's experiences with other services were negative. For example, some women felt that these other providers had not been helpful: "We, like I told you, had received psychological help as a couple and individually over here in the district attorney's office, but by the looks of it, it didn't help us. Well, I did learn a lot, but it didn't help him absolutely at all." Others felt that the services had not been organized, safe, or confidential. Serious complaints were also made of victim-blaming, not believing victims, and not taking violence seriously unless very severe, especially psychological abuse or physical abuse without injury. Service providers were portrayed as insensitive, untrained, indifferent, and unknowledgeable:

> *Of course, and more than anything in all of the state offices, you see some pretty ignorant people, forgive my language. People think like Maria said, that they're doing us a favor and knowing that a person goes to them and on top of that they tell them, "Why did you let yourself get hit?" There are a lot of people who don't even have a little bit of training on how to treat people, how to treat people who are suffering violence. There's quite a bit of that in Quito.*

I've been in this for 12 years, but I come because I have a need. So then at first they humiliate you to be able to give you anything. First they humiliate you, then they throw it in your face, they don't give it to you, if they give it to you first they humiliate you, if they give it to you, if they help you with something, but first they humiliate you psychologically and then later they give you something.

Participants also expressed frustration with services that forced them to retell their stories over

and over again or that offered fragmented services such that the women needed to go to several different offices, with none actually helping:

> *First you arrive at the psychologist of whichever place, "Well, what's your name?" they say. Click, click, click. "You know that you are going to get care, and this and that." "Ok, tell me what's going on." Click, click, click. And you feel that the regret comes back and you give another go of things that you don't want to talk about anymore, you don't even want to remember it anymore, you want to put it in a book and burn it, make the ashes disappear and even the dust because all of it is traumatic for you. So then at the third appointment they tell you, "Ok, girl, you need to make decisions, you alone need to heal yourself." Please … we don't live off slaps to the face, we didn't come here so that someone could hit us.*

They also noticed the irony in mental health professionals ushering them to change their lives in a short period of time or treating the victim with medication and not doing anything about the abusive behavior itself. One participant even reported being sexually harassed by a psychologist at a previous service location. Others shared stories of how their abusive partners used the criminal justice system to further abuse and control them:

> *He filed two complaints against me. He accused me of psychological violence, when he was the one who attacked me, he hit me, I endured it and I never said anything, trying to preserve my marriage and everything else. He yelled at me, he kicked me, he hit me, sometimes he hit me in the face, horrors, and I said nothing. Later, what happens, he gets a restraining order, and they lock me up for a whole day, without notifying me before. They had to notify me.*

One woman summed it up by saying, "*Hay que tener suerte* [you need to have luck] so that the person says, 'Yes, we are going to support you.'"

Discussion

The way in which victim services are delivered is an important human rights issue that has a substantial bearing on women's ability to live violence-free and healthy lives. Quality victim services enhance the well-being of survivors, while a failure to respond adequately poses yet another violation to victims' human rights. Available, accessible, adaptable, and appropriate services are needed across the domains of health, criminal justice, and social services in order to advance human rights. From this sample of users of particular social and legal services, there appears to be wide variability across experiences. While participants tended to report more positive experiences with their current service providers, their difficulties in accessing services (accessibility) and receiving all of the support they needed (availability and adaptability) showed that these services still need to be improved to meet international standards. Further, women's recollections of previous service experiences, especially concerning the criminal justice system, were negative overall.

The *Essential Services Package* calls for social service organizations to provide specific forms of support, including crisis counseling, safe accommodations, woman-centered support, psychosocial counseling, services for children, community outreach, and assistance toward economic independence.[40] These were all concerns of our focus group participants. Across the focus groups, participants expressed a desire for support for economic independence via skills training and sponsorship (availability) so that they could navigate their particular economic situation (adaptability). Other areas that appear to be limited in availability, as mentioned in the *Essential Services Package*, include community outreach (mentioned by one participant), help lines (dedicated help lines not mentioned by any participant), and prevention (mentioned as a suggestion). Accessibility was largely limited by a lack of information, including for the women who sought services. One aspect of limited availability that focus group participants mentioned was services for children and men in conjunction with services for women. The women in our sample did not focus on separation and independence as the only way to gain safety; in fact, one-third were currently in their abusive relationships. Rather, some appeared to want solutions that maintained the family structure. Lastly, the appropriateness of services, particularly previous services, was diminished by a lack of sensitivity

among personnel.

As revealed by participants, the issue of accessibility extended beyond physical, economic, and linguistic barriers and included the juggling of multiple roles (for example, employee, mother) and a lack of information. Indeed, several participants commented on how their knowledge of services was limited—either they did not know about services or their network did not know about available services. This lack of information is a specific barrier that could be overcome with an organized effort. Effective strategies include the training of public employees such as those working in police departments, district attorney's offices, public aid offices, and the like; the distribution of information via educational and community institutions; general public service announcements; and the distribution of directories. The *Essential Services Package* acknowledges the importance of making crisis information available and accessible in a variety of locations in different formats. It notes that community information, which should be available in culturally appropriate ways, includes information on the rights of women, where to seek help, available services and how to access them, and what to expect when seeking services.[41] This appears to be an area in need of attention in Quito.

The issue of adaptability requires service providers to understand the particular circumstances of victims and to meet those needs. Participants noted that this was done in a variety of situations, but they yearned for more alternatives with regard to economic empowerment. Economic empowerment can be helpful in decreasing women's dependence on potentially abusive partners and improving the economic well-being of the family unit; but it can also be linked to increased violence in abusive relationships if the abusive partner views economic empowerment as a threat or seeks to control economic productivity.[42] Economic empowerment programs tend to focus on financial literacy, economic self-efficacy, and economic self-sufficiency.[43] While participants focused on economic self-sufficiency (specifically microenterprises), other aspects of economic empowerment (such as obtaining and navigating loans and learning about business accounting) may also be helpful. Women's insistence on the ability to make their own money via skills such as cooking echoes the fact that 95% of businesses in Ecuador are microenterprises.[44] Yet, violence against women could thwart the success of such businesses (for example, lost days of work due to violence, destruction of property by abusive partner, and emotional distress). In fact, more than half of women entrepreneurs in Ecuador have suffered from partner violence.[45] Thus, while economic empowerment is a vital and worthy goal, there are still complex safety issues that need to be addressed.[46] Furthermore, a realistic understanding of these businesses is important: there is no fixed income, there are very few labor laws for protection, and there are no benefits such as health insurance and investments.[47] Economic advancement initiatives need to account for the complexity of issues at play, as well as respond to the context of such endeavors.

Another aspect of adaptability that was stressed by focus group participants includes services for children and partners. The desire for services for children often stemmed from an acknowledgement of the difficulties that children in abusive families have lived through. Research shows that child witnesses to domestic violence suffer from psychological, social, and academic problems.[48] Participants desired help so that their children could understand and negotiate relationships in a healthy way. Additionally, children have the right to such protections through international instruments such as the Convention of the Rights of the Child, which indicates that states must protect children from maltreatment and abuse.[49] Similarly, participants desired services for men so that they could heal from the violence they too have endured. While family preservation was not an explicit goal of most participants, many did want more aid than just for themselves. There was a sense of unfairness and irony identified by participants: their partners are abusive, yet the women are the ones seeking psychological services. Thus, family preservation could be one of the driving goals, but this desire could also speak to a need for abusive men to be held accountable for their actions and could be seen as a way to rebuke victim-blaming attitudes.

Another important issue identified by participants is the lack of understanding and empathy among some service providers. Protocols in Ecuador explicitly identify the need for specialized and trained professionals to provide ample information to victims so they can make decisions without being revictimized. This is also specified in the Convention of Belém do Pará. However, few women in the focus groups experienced such understanding and empathy. More generally, they reported insensitive, untrained personnel who did not aid in their treatment. Efforts to counteract these trends could include thorough trauma-informed training from a rights-based perspective for all personnel and could extend to seeking cultural shifts in the understanding of violence against women, as specified in the convention. Unfortunately, victim-blaming attitudes, based in gender inequality, continue to prevail in many countries, including Ecuador.

Conclusion

The findings here show mixed support with respect to the standards set out in the Convention of Belém do Pará, including the rights to dignity, to equal protection before the law, and to be free of stereotyped patterns of behavior based on gender inequality. While services and legal remedies were offered, they were offered unevenly. Further, the convention indicates that the state should train staff delivering these services, "provide readjustment and training programs to enable [victims] to fully participate in public, private and social life," raise the awareness of the public, and provide "counseling services for all family members where appropriate."[50] Efforts such as violence prevention, public awareness raising, economic empowerment, trauma-informed services, and services for children are in line with fulfilling these mandates and the desires of victims. A very important contribution of these women is how they connect the violence they have experienced to their well-being in various aspects of their lives. This underscores other dimensions of human rights: interdependence and interrelatedness. Human rights are interdependent—all rights are connected and needed to achieve well-being.[51] Economic rights are linked to the right to live free from violence. Thus, other state obligations, such as those outlined in the International Covenant on Economic, Social and Cultural Rights (which, among other things, underscores the need for gender equality in work and pay), can work to foster nonviolence.[52]

Some of the limitations of this study include a racially and linguistically homogenous sample, which restricted our ability to understand accessibility for diverse groups. Further, the goal of the focus groups was not to obtain a detailed account of each service rendered but rather to discuss participants' current service experiences. Our recruitment of focus group participants was facilitated by the service providers, meaning that dissatisfied or hard-to-reach users could have been excluded. A comprehensive evaluation of services would include various other dimensions, such as objective outcome measures, inclusion of those who discontinue services, and observation of service provision. Nonetheless, the sample of 21 service users provides meaningful insights into gender-based violence service provision in Quito, Ecuador, from users' own perspectives.

The *Essential Services Package* provides a roadmap for increasing access to services for women who are victims of gender-based violence in low-income countries. Using this framework, which is guided by a rights-based approach to health, has proven effective for discovering some of the strengths and weaknesses of the victim service delivery model in Quito. Overall, there are a limited amount of services available, but the experiences shared by participants underscore the vital and life-saving role of victim services. Continued efforts—including more funding, staff, programs, and training—are needed to meet the varied and complex needs of victims and to realize all women's right to health in situations of gender-based violence.

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References

1. Universal Declaration of Human Rights, G.A. Res. 217A (III) (1948).
2. R. McQuigg, "Domestic violence: Applying a human rights discourse," in S. Hilder and V. Bettinson (eds), *Domestic violence: Interdisciplinary perspectives on protection, prevention and intervention* (London: Palgrave Macmillan, 2016); P. Goldberg and N. Kelly, "International human rights and violence against women," *Harvard Human Rights Journal* 6 (1993), pp. 195–209.
3. General Assembly, Declaration on the Elimination of Violence against Women (1993); Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women (Convention of Belém do Pará) (1994).
4. UN Women, United Nations Population Fund, World Health Organization, et al., *Essential services package for women and girls subject to violence* (2015). Available at http://www.unwomen.org/en/digital-library/publications/2015/12/essential-services-package-for-women-and-girls-subject-to-violence.
5. International Convention on the Elimination of All Forms of Discrimination against Women, G.A. Res. 34/180 (1979).
6. Committee on the Elimination of Discrimination against Women, General Recommendation No. 19, Violence against Women (1992).
7. Declaration on the Elimination of Violence against Women (see note 3).
8. Inter-American Convention on the Prevention, Punishment, and Eradication of Violence Against Women (see note 3).
9. N. Jubb, G. Camacho, A. D'Angelo, et al., "*Comisarías de la Mujer en América Latina: Una puerta para detener la violencia y acceder a la justiciar* (Quito: Centro de Planificación y Estudios Sociales, 2010).
10. *Ley Contra la Violencia a la Mujer y a la Familia*, No. 103 (1995).
11. Constitution of Ecuador (2008), art. 66(3)(b).
12. Ibid.
13. *Código Orgánico Integral Penal* (2014).
14. Ministerio de Justicia, *Plan nacional de la erradicación de la violencia de género hacia niñez, adolescencia y mujeres* (2007). Available at https://www.justicia.gob.ec/wp-content/uploads/2014/08/plan_erradicacionviolencia_ecuador.pdf.
15. Instituto Nacional de Estadística y Censos, *Encuesta nacional de relaciones familiares y violencia de genero contra las mujeres* (Quito: Instituto Nacional de Estadística y Censos, 2014).
16. J. C. Campbell and L. A. Lewandowski, "Mental and physical health effects of intimate partner violence on women and children," *Psychiatric Clinics of North America* 20/2 (1997), pp. 353–374.
17. UN Women et al. (see note 4).
18. R. Penchansky and J. W. Thomas, "The concept of access: Definition and relationship to consumer satisfaction, *Medical Care* 19 (1981), pp. 127–140.
19. C. Sabina and D. Pérez Figueroa, "Servicios de atención contra la violencia de pareja en Quito, Ecuador," *Nuestra Mirada* 2 (2016), pp. 47–64.
20. S. Balarezo, *El silencio es … complicidad: Sistematización del proyecto fortalecimiento del acceso a la justicia y ejercicio de ciudadanía, por una vida libre de violencia para jóvenes y mujeres de Quito* (Quito: Centro Ecuatoriano para la Promoción y Acción de la Mujer, 2010).
21. M. Sagot, "The critical path of women affected by family violence in Latin America: Case studies from 10 countries," *Violence against Women* 11 (2005), pp. 1292–1318.
22. Sabina and Pérez Figueroa (see note 19).
23. Corporación Utopía, *Sistematización de las Comisarías de la Mujer y la Familia, 2000* (Quito: Centro Ecuatoriano para la Promoción y Acción de la Mujer, 2000).
24. M. Cuvi Sánchez, *Violencia contra las mujeres: La ruta crítica en Ecuador* (Quito: OPS/OMS, 1999).
25. Ibid.
26. Ibid.
27. Sagot (see note 21).
28. Ministerio de Justicia (see note 14); Jubb et al. (see note 9).
29. C. Medina and P. Carrillo, *Los lenguajes de la impunidad, Informe de investigación delitos sexuales y administración de justicia* (Quito: Centro Ecuatoriano para la Promoción y Acción de la Mujer, 2007).
30. A. Soledispa Toro, *Se hace camino al andar… Sistematización de las propuestas metodológicas desarrolladas por los servicios penales para la atención a víctimas de delitos sexuales en las ciudades de: Quito, Guayaquil, Cuenca, Esmeraldas y Portoviego* (Quito: Centro Ecuatoriano para la Promoción y Acción de la Mujer, 2007).
31. Cuvi Sánchez (see note 24).
32. Balarezo (see note 20).
33. Medina and Carrillo (see note 29).
34. Ministerio de Justicia (see note 14).
35. Corporación Utopía (see note 23); Sagot (see note 21).
36. Medina and Carrillo (see note 29); Cuvi Sánchez (see note 24).
37. Jubb et al. (see note 9).
38. S. Appe and D. Barragán, "Universities, NGOs, and civil society sustainability: Preliminary lessons from Ecuador," *Development in Practice* 27 (2017), pp. 472–486.
39. W. J. Gibson and A. Brown, *Working with qualitative data* (London: Sage, 2009).
40. UN Women et al. (see note 4).
41. Ibid.
42. M. Bolis and C. Hughes, *Women's economic empowerment and domestic violence* (Boston: Oxfam America, 2015).
43. J. L. Postmus, *Economic empowerment of domestic violence survivors* (Harrisburg, PA: VAWnet, 2010).
44. C. Brendel and V. Maldonado, *The invisible costs of*

violence against women for Ecuadorian micro-enterprises (Lima: GIZ, 2014).

45. Ibid.

46. Postmus (see note 43).

47. Brendel and Maldonado (see note 44).

48. K. M. Kitzmann, N. K. Gaylord, A. R. Holt, and E. D. Kenny, "Child witnesses to domestic violence: A meta-analytic review," *Journal of Consulting and Clinical Psychology* 71 (2003), pp. 339–352.

49. Convention on the Rights of the Child, G.A. Res. 44/25 (1989).

50. Inter-American Convention on the Prevention, Punishment, and Eradication of Violence Against Women (see note 3).

51. T. McDowell, K. Libal, and A.L. Brown, "Human rights in the practice of family therapy: Domestic violence, a case in point," *Journal of Feminist Family Therapy* 24/1 (2012), pp. 1–23.

52. International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI) (1966).

Evaluating the Impact of Student-run Asylum Clinics in the US from 2016–2018

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Abstract

Individuals applying for asylum must demonstrate a well-founded fear of persecution. By documenting signs of torture and other forms of abuse, medical evaluations can provide forensic evidence to support asylum claims. The backlog of pending immigration cases in the United States recently exceeded one million. Student-run asylum medicine clinics conduct forensic evaluations to assist in the asylum adjudication process. The Physicians for Human Rights National Student Advisory Board administered surveys to student-run clinics in the US in 2017 and 2018. Retrospective analysis evaluated the completion rates of forensic evaluations, caseload capacities, and training frequencies. Student-run asylum clinics completed 38.8% more forensic evaluations in 2017 than in 2016. In 2016, 33% of clinics received forensic evaluation requests that exceeded their capacity, a figure that rose to 50% in 2017. The number of clinicians trained by asylum clinics increased nearly fourfold between 2016 and 2017, and the number of students trained grew by 81%. A recent surge in armed conflict has contributed to record numbers of asylum applications in the US. The results of this survey reveal the burgeoning capability of student-run asylum clinics to provide evaluations, a trend that underscores medical students' ability to significantly impact human rights issues. Student-run asylum clinics are poised to fill an increasingly important role in supporting victims of torture and persecution.

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Competing interests: Dr. McKenzie is a long-term volunteer for Physicians for Human Rights and HealthRight International. She was paid less than $300 for each of two PHR trainings conducted in 2015 and 2016. When she provides asylum detention evaluations for American Friends Service Committee, her travel expenses are compensated. She was paid less than $500 in travel expenses to present grand rounds at Stony Brook University.

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Introduction

An asylum seeker is a person who has left their country of origin due to persecution or fear of future persecution and whose request for sanctuary has yet to be processed. They are seeking the right to be recognized as a refugee and be granted legal and other protection. There are two ways to apply for asylum in the United States (US): the affirmative process and the defensive process. To apply affirmatively, an individual must be present within the US and submit Form I-589 within a year of arriving. A person in the defensive asylum process requests asylum in immigration court as a defense against deportation. Tens of thousands of individuals seek asylum in the US each year to escape persecution or torture in their home countries.[1] Human rights violations, armed conflict, and worsening humanitarian crises have contributed to the nearly 1.7 million new asylum applications reported worldwide in 2017, a substantial increase from years prior.[2] With 331,700 new claims, the US received the most asylum applications of any country in 2017.[3] The backlog of immigration cases in the US, including pending asylum claims, reached 642,700 in 2017, nearly 50% more than in 2016.[4] Fewer than 40% of applicants are granted asylum in the US: only 26,568 individuals obtained asylum in 2017.[5]

Individuals seeking asylum bear the burden of proof to demonstrate persecution, most of whom carry scars on their bodies and minds as the only forensic evidence of the abuses they have suffered. Through forensic evaluations, trained clinicians identify sequelae of trauma and document their findings in affidavits.[6] These medico-legal documents can help corroborate the experiences of asylum seekers and consequently help victims of torture or abuse access justice through asylum. However, lawyers have only limited access to trained physicians.[7] By connecting immigration attorneys to clinicians, asylum clinics housed at medical schools significantly expand access to *pro bono* forensic evaluations and critical documentation. These clinics, many of which are student-led initiatives, serve as organizing hubs that pair clinicians with students to perform evaluations, educate providers and trainees about asylum and human rights, and connect asylum seekers to medical and social services. These organizations generally comprise a team of medical students that manages the clinic's operations and receives guidance from student and faculty leaders.[8]

Physicians for Human Rights (PHR), a non-governmental organization devoted to advocating for health and human rights, works closely with asylum clinics and provides resources to train the next generation of evaluators. The PHR National Student Advisory Board comprises a team of medical students who streamline communication between PHR student chapters and the PHR national office. The board aims to inspire medical students to address health and human rights violations now and in their future careers. Within the PHR National Student Advisory Board, the Asylum and Refugee Committee is tasked with guiding nascent student-run asylum clinics and with troubleshooting challenges that existing clinics are facing. Student-run organizations that perform forensic evaluations now exist at 19 medical schools across the US.[9]

The utility of forensic evaluations in asylum proceedings has been examined previously: in one study, 89% of US asylum seekers with legal representation who also received a PHR medical evaluation were granted protective status, far exceeding the national average of 37.5% among asylum seekers—with and without legal representation—who did not receive PHR evaluations.[10] The impact of student-run asylum clinics, however, has not yet been documented. Here, we report the growth of the Weill Cornell Center for Human Rights (WCCHR), the first student-run organization to partner with PHR, and we share the results of the 2017 and 2018 national surveys of student-run asylum clinics that investigated caseloads, asylum evaluation trainings, clinician and student involvement, and operational challenges.

Methods

Study setting

The Asylum and Refugee Committee of the PHR National Student Advisory Board conducted two

surveys of all student-run asylum clinics, including those affiliated and not affiliated with PHR, across the nation; the first was administered from September to December of 2017 and the second over the same time interval in the following year. Clinics were emailed a link to the online, standardized questionnaire. Data was collected for the preceding year and for the clinic's entire history. The survey sought to evaluate the impact of student-run asylum clinics and to identify ways that clinics could improve the services offered to clients. The Institutional Review Board at Yale University was consulted and concluded that the data obtained by this study did not constitute human subjects research.

Questionnaire design

The survey (included here as an appendix) contained queries that addressed several topics: caseloads, client outcomes, asylum-evaluation trainings, active clinician and student involvement, and challenges faced. Regarding caseloads, the survey asked for the total number of forensic evaluations performed and the number of clients evaluated in the preceding year and since a clinic's inception; the numbers of physical, psychological, and gynecological evaluations performed in the preceding year and throughout the clinic's history; the number of evaluations performed in detention facilities; and the volume of forensic-evaluation requests received compared to the organization's capacity to perform evaluations.

The number of evaluations performed by a clinic may not equal the number of clients served for two reasons: Firstly, some clients require multiple types of evaluations. Secondly, certain clinicians may perform multiple types of evaluations for a client in the same session and the clinic may employ different conventions for how such evaluations are counted. These discrepancies were clarified during annual conference calls with each clinic as part of a quality-improvement initiative administered by the Asylum and Refugee Committee. Additionally, a convention was adopted wherein the total number of evaluations performed by a clinic was calculated as the sum of the numbers of physical, psychological, and gynecological evaluations performed.

The survey's section on client outcomes requested information about the number of cases granted and denied asylum or other forms of legal protection. Clinics were asked to report the number of asylum evaluation trainings and the numbers of clinicians and students trained in 2016 or 2017 and since the organization's founding. Finally, clinics were asked to provide the number of clinicians and students involved in performing forensic evaluations. In the second survey, administered in 2018, clinics were asked whether they provided services in addition to forensic evaluations and whether recent legislative changes had affected their operations. No incentives were offered for participation.

Statistical analysis

Categorical variables are reported as counts and percentages, and continuous variables as means and standard errors. The linear least squares method was employed to identify the best-fit quadratic curve that estimates the rate of growth in the WCCHR's capacity to perform evaluations. All calculations were performed by using Mathematica (Version 10.1; Wolfram).

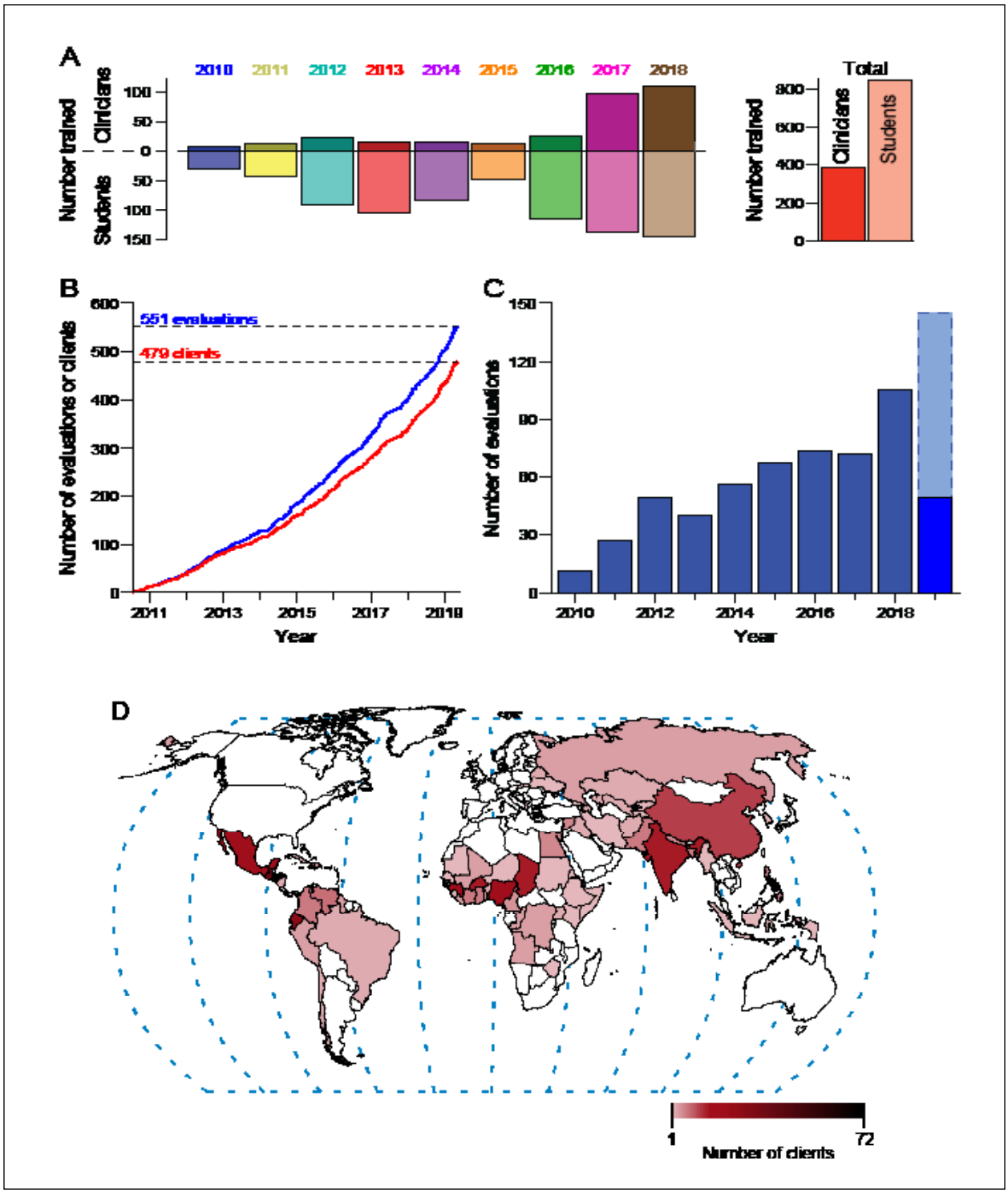
Results

The Weill Cornell Center for Human Rights: A case study

The WCCHR is the first student-run asylum clinic to collaborate with PHR. Since its founding in 2010, the WCCHR has trained 386 clinicians and 845 students to conduct forensic medical evaluations of asylum seekers. The trainings with the largest attendance were held in 2017 and 2018. Strikingly, the number of clinicians trained in 2017 was nearly fourfold greater than the number trained in 2016 (Figure 1a).

The WCCHR has performed a total of 553 evaluations for 479 clients from 7/14/2010 through 5/4/2019. Because some clients require multiple types of evaluations, the number of evaluations performed exceeds the number of clients evaluated. Plotting the cumulative number of evaluations performed versus time yields a curve with a rising slope, reflecting the clinic's expanding capacity to perform evaluations (Figure 1b). In contradistinction, a constant slope

FIGURE 1. Growth of the Weill Cornell Center for Human Rights (WCCHR)



(a) Numbers of clinicians and students trained by the WCCHR each year (left) and in total (right). The upright, darkly shaded bars in the left panel show the numbers of clinicians trained, whereas the downward, lightly shaded bars show the numbers of students trained.
(b) Cumulative number of clients seen (red) or forensic evaluations performed (blue) by the WCCHR from 7/14/2010 through 5/4/2019.
(c) Number of evaluations performed annually by the WCCHR. The lightly shaded bar with the dashed border indicates the projected number of evaluations for 2019.
(d) Map showing the 74 countries from which the WCCHR's clients fled to seek asylum in the United States. Darker shades indicate greater numbers of clients from those countries; white indicates that no clients were seen from those countries. The color bar indicates the range of the number of clients seen.

would be seen for an unchanging number of evaluations performed per unit time. The change in the curve's slope, calculated as the second derivative of the best-fit quadratic curve, estimates that each year the WCCHR performs on average nine evaluations more than the number performed in the previous year. However, the rate of increase observed for 2019 so far exceeds this estimate.

Tabulating the number of evaluations performed annually by the WCCHR again demonstrates the clinic's expanding capacity (Figure 1c). On average, the number of evaluations performed in a year increased by 12 cases, corresponding to an average annual growth of 40%. Assuming that the volume of cases remains constant throughout the year, the WCCHR is projected to perform 145 evaluations in 2019.

Forty-six percent of the clients evaluated by the WCCHR were men, 53% were women, and 1% were transgender. The average age of a client was 31 (age range was three to 65). The WCCHR offers three types of evaluations: 27% of the evaluations performed were physical, 65% psychological, and 8% gynecological. Clients most frequently hailed from Central America (38.2% of clients), Africa (26.9%), South America (12.9%), and Asia (11.9%), with the greatest numbers of clients coming from Honduras (n=72 clients), El Salvador (n=60), and Guatemala (n=37) (Figure 1d). The most common ground for claiming asylum was membership in a particular social group (78.7% clients), followed by political opinion (35.9%), religion (8.8%), race (5.6%), and nationality (3.6%). Of the clients whose cases were adjudicated, 95% received asylum or another form of legal protection. Immigration courts in New York decided the vast majority of these cases and had the highest rate of granting asylum or other legal protection in 2018 (Figure S1a) and with the third-largest backlog of pending immigration cases in the same year (Figure S1b).[11]

National trends in clinic caseloads and outcomes

Of the 15 clinics contacted in 2017, 14 responded, whereas 15 of 18 clinics contacted in 2018 responded (Figure 2a). Between 2017 and 2018, two new organizations were founded and one existing clinic was identified; all three were added to the list of surveyed clinics in 2018. Two clinics that responded in 2017 did not respond in 2018. Complete caseload data were obtained by both the 2017 and 2018 surveys for 11 clinics. In 2016, these 11 clinics performed a total of 227 evaluations for 192 individual clients: 87 (38%) of the evaluations were physical, 122 (54%) were psychological, and 18 (8%) were gynecological. Fifteen evaluations were performed in detention centers. The same 11 clinics completed 315 evaluations for 275 clients in 2017. The number of evaluations performed thus grew by 38.8% or by an average of 8 ± 3 cases per clinic over the preceding year, and the number of clients served grew by 43.2% (Figure 2b). Nine clinics performed more evaluations in 2017 than in 2016, whereas two clinics performed fewer evaluations. One hundred and fifty (48%) of the 2017 evaluations were physical evaluations, 130 were psychological (41%), and 35 (11%) were gynecological (Figure 2c, inset). Compared to the 2016 data, these figures constitute an increase in physical evaluations by 72.4%, an increase in psychological evaluations by 6.6%, and an increase in gynecological evaluations by 94.4% (Figure 2c). Thirty-one evaluations were performed in detention centers in 2017, more than double the number performed in 2016. In both years, nine clinics served clients who required multiple types of evaluations. Several entities referred forensic evaluation requests to clinics, including PHR, non-profit organizations, law clinics, and attorneys.

To date, student-run clinics have performed more than 1,600 evaluations, of which approximately 39% were physical evaluations, 52% were psychological evaluations, and 9% were gynecological evaluations. Ninety evaluations were completed at detention centers. Outcomes were reported for 774 clients: 754 clients (97.4%) were granted asylum or another form of legal protection, and 20 clients (2.6%) were denied asylum. The majority of student-run asylum clinics are located in states whose immigration courts grant asylum or other protections at a rate that exceeds the nation's average grant rate (Figure S1a) and in states with long backlogs of pending immigration cases (Figure S1b).[12]

In 2016, half of the clinics stated that the volume of forensic evaluation requests received by their organization was commensurate with their capacity to perform evaluations, 33% claimed their capacity for forensic evaluations exceeded the number of requests they received, and 17% stated the forensic evaluation requests they received exceeded their organization's capacity. By 2017, 50% of clinics received evaluation requests exceeding their organization's capacity, 25% received evaluation requests commensurate with their organization's capacity, and 25% of clinics' capacity exceeded the number of requests (Figure 2d).

National trends in asylum evaluation trainings

In 2016, five clinics held two trainings, three clinics held one training, and the remaining clinics held no trainings. In 2017, three clinics held two trainings, six clinics held one training, seven clinics held no trainings, and three clinics did not respond. Complete training data were obtained by both surveys for seven clinics; these clinics trained 76 clinicians

FIGURE 2. Caseloads for student-run asylum clinics

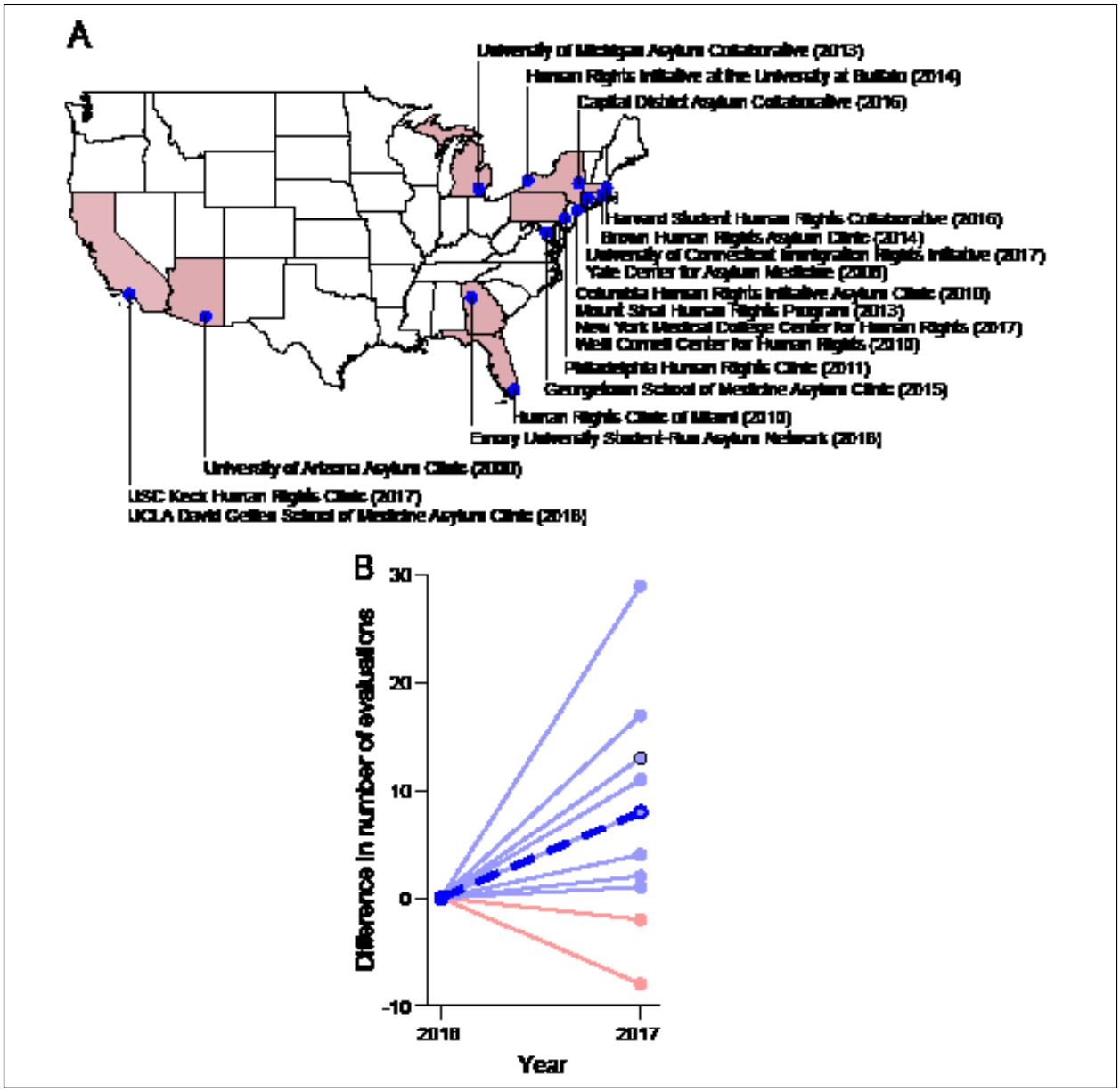
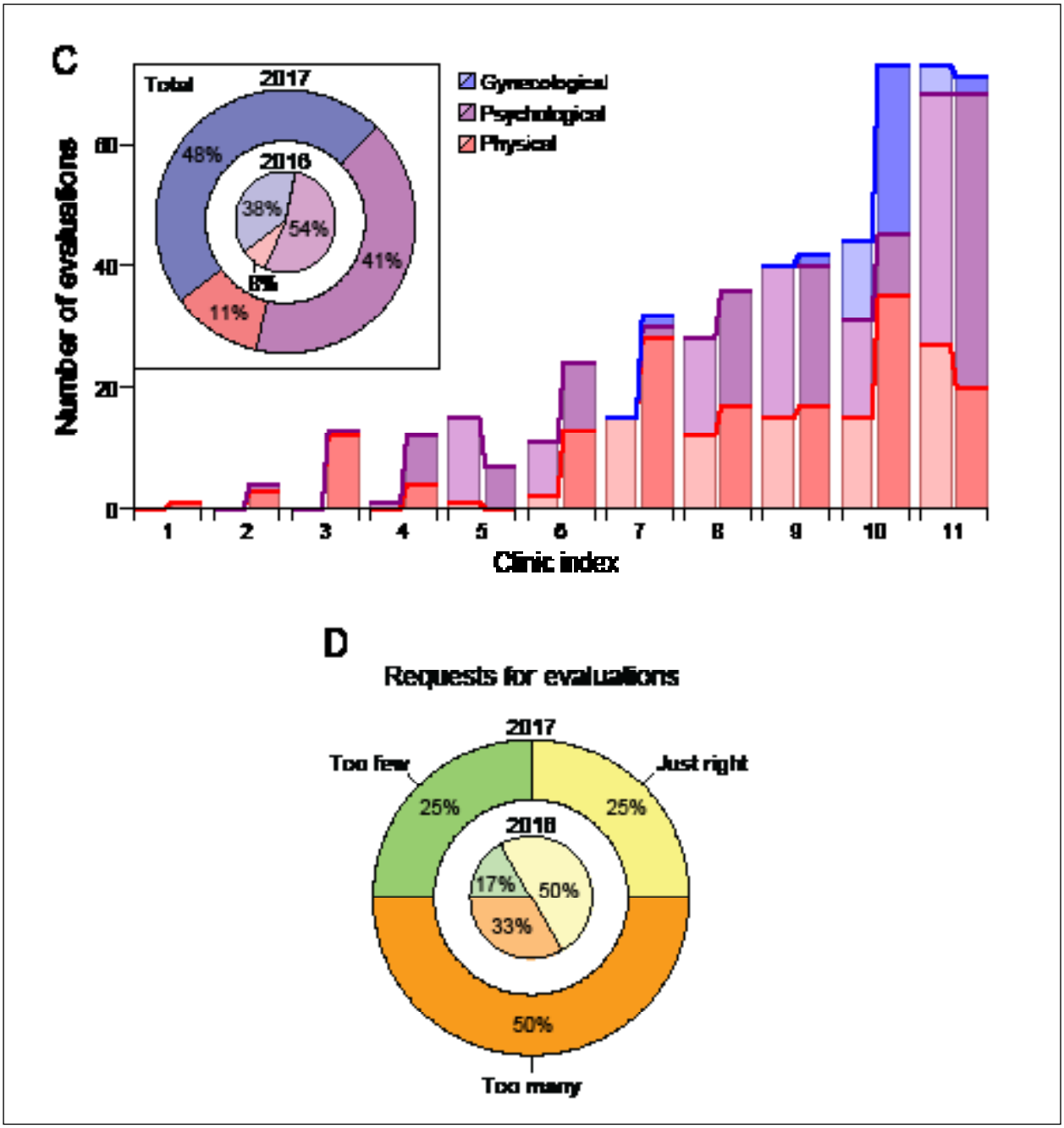


FIGURE 2. *cont'd*. Caseloads for student-run asylum clinics



(a) Map showing the 18 active organizations that received the survey in 2018. The founding year of each clinic is listed in parentheses. Because they had not yet performed a forensic evaluation by the end of 2018, the student-run organizations at the Albert Einstein College of Medicine, CUNY School of Medicine/Sophie Davis, Geisel School of Medicine at Dartmouth, Touro College of Osteopathic Medicine, NYIT College of Osteopathic Medicine, and UTMB at Galveston are not shown.
(b) Differences in the numbers of evaluations performed between 2017 and 2016. Data is shown only for the eleven clinics from which complete training data were obtained for both surveys. Light-blue lines indicate an increase in the number of evaluations, whereas light-red lines indicate a decrease. The thick, blue, and dashed line represents the average difference across clinics. A black circle indicates that the same difference was obtained for two clinics.
(c) Bar chart depicting the numbers of each type of evaluation (physical, psychological, and gynecological) performed by each clinic. Light shades of each color correspond to data from 2016, and darker shades portray data from 2017. The inset displays the proportions of evaluation types among all evaluations performed in 2016 (inner circle) and in 2017 (outer circle).
(d) Pie chart showing the proportion of clinics that reported receiving a number of evaluation requests that exceeded the organization's capacity ("too many"), receiving a number of evaluation requests that was commensurate with the organization's capacity ("just right"), or having capacity that exceeded the number of received evaluation requests ("too few"). Data are shown for 2016 (inner circle) and for 2017 (outer circle).

and 186 students in 2016, and 377 clinicians and 337 students in 2017, reflecting a growth by 396% and 81% in the numbers of clinicians and students trained, respectively. On average, clinics trained 43.0 ± 16.6 more clinicians and 21.6 ± 7.2 students in 2017 than in 2016 (Figures 3a and 3b). To date, 12 clinics have together hosted 66 trainings that were attended by more than 1,400 clinicians and by more than 1,700 students in total. Moreover, nearly 400 clinicians and more than 1,000 students were reported to be actively involved in the clinics at the end of 2018.

Additional services offered by clinics

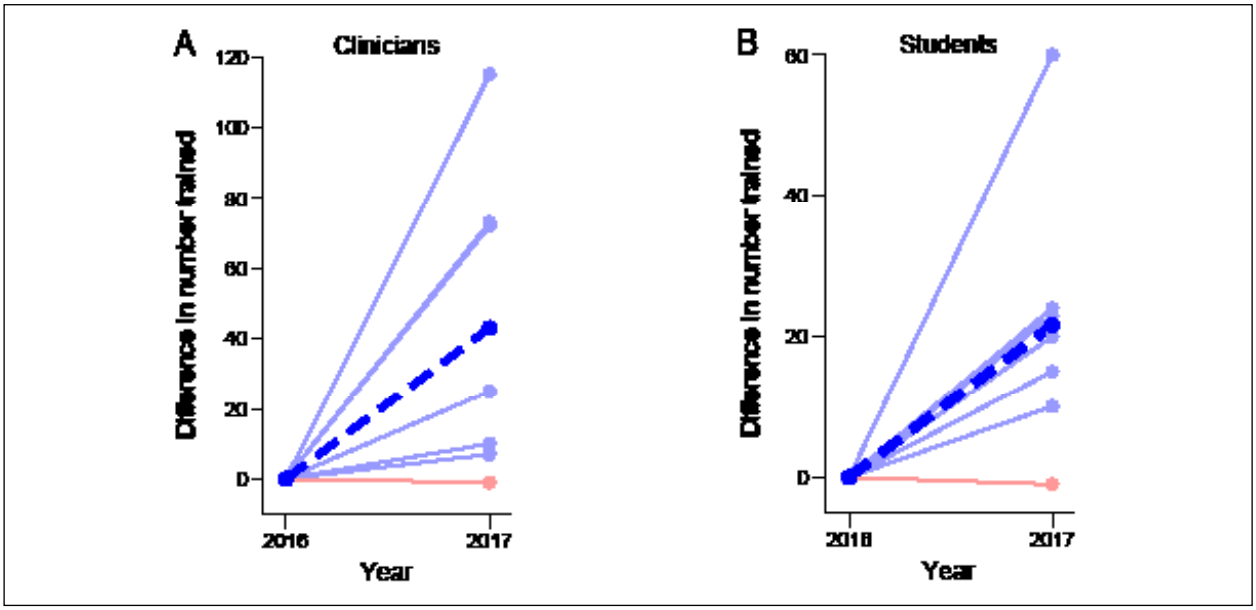
In 2018, a third of the clinics provided services in addition to forensic evaluations. Six clinics refer clients to local organizations that provide clients with *pro bono* or low-cost legal, medical, or psychological services. Other services included on-site social work and counseling for survivors of intimate-partner violence and sexual assault; a travel fund to help clients attend appointments; and financial assistance with clothing, food, and infant care necessities.

Challenges faced by nascent and established clinics

Challenges were shared by 13 respondents in 2017 and by 12 respondents in 2018. Most challenges were recurrently reported and were related to institutional difficulties, to recruitment or retention of clinicians, or to changes in national policies. Institutional obstacles included: gaining support from the medical school's administration, finding physical spaces for evaluations, and answering questions about liability. Concerns around ensuring the continuity of services and around maintaining the organization's knowledge across student-leadership transitions were also listed. Two clinics reported barriers to developing an apparatus that addresses clients' ongoing medical and social needs. One of these clinics was unsure of how to implement such a framework without affecting the perceived objectivity of the forensic affidavits and evaluations.

Difficulties related to having enough volunteer clinicians were reported most commonly: six clinics (43% of respondents) in 2017 and six (40% of respondents) in 2018 cited such challenges. Specifically, some clinics had trouble attracting clinicians

FIGURE 3. Asylum evaluation trainings



Differences in the numbers of clinicians (a) and students (b) trained between 2016 and 2017. Data is shown for only the seven clinics from which complete training data were obtained for both surveys. Light blue lines indicate an increase in the number of trainees, whereas light red lines indicate a decrease. The thick, blue, and dashed line represents the average difference across clinics.

to training opportunities, recruiting clinicians to become active evaluators, or retaining trained clinicians. A shortage of mental health professionals to perform psychological evaluations was noted by two clinics in 2017 and by two different clinics in 2018. In 2017, one clinic reported having difficulty placing urgent evaluation requests—those needing to be completed within a short timeframe—with clinicians, an issue that arose for three clinics in 2018.

Two-thirds of clinics responded affirmatively to the question: "Have recent legislative changes affected the way in which your clinic operates?" Six clinics (40%) noted differences in how domestic violence or gang violence cases were handled by the organization or by legal partners. Four clinics (27%) connected rising caseloads to policy changes, with three of these clinics noting an increase in the number of urgent requests for evaluations. Two clinics saw diminished numbers of evaluation requests, and one of these clinics specifically reported having far fewer referrals for clients who were subjected to domestic violence.

Discussion

Forensic evaluation statistics

This study reports caseloads, training statistics, active involvement, and challenges for student-run asylum clinics. The growth experienced by the WCCHR augurs the trends seen for organizations across the nation. Eleven clinics performed 227 forensic evaluations in 2016 and 315 evaluations in 2017, reflecting a growth in capacity by 38.8%. By comparison, PHR conducted 520 evaluations in 2016 and 670 evaluations in 2017, representing growth by 28.8%.[13] Considering that PHR is one of the largest providers of evaluations in the nation, these figures suggest that student-run clinics will soon manage the majority of requests for forensic medical evaluations. This prediction is further supported by the close agreement seen between the WCCHR's average annual growth rate (40%) and the growth rate averaged over 11 clinics in various stages of development (38.8%). The WCCHR's experiences are likely typical, and student-run asylum clinics in urban centers can expect to follow a similar trajectory. Greater capacities to accommodate evaluation requests are urgently needed as the number of asylum claims filed in the US continues to rise each year: in 2017, the US Citizenship and Immigration Services (USCIS) reported 139,801 affirmative asylum applications, surpassing the 2016 number by 21%.[14]

Greater numbers of all evaluation types—physical, psychological, gynecological, and those conducted in detention facilities—were performed in 2017 than in 2016. That the number of psychological evaluations grew by only 6.6% might reflect the challenge of recruiting mental health professionals that was cited by several clinics. Various studies place the rates of post-traumatic stress disorder in asylum seekers at different percentages ranging from 20% to 80%.[15] The psychological harm that has befallen asylum seekers may impair their ability to recall facts or to coherently recall their experiences. Mental health professionals and physicians who routinely perform psychological assessments provide diagnostic information to support applicants' claims of psychological harm, thereby enhancing a claimant's credibility.[16] The expertise of mental health professionals is needed with even greater urgency following the implementation of Executive Order 13767 in 2017 and the higher standard for "credible fear" of persecution therein established.[17] Under this order, asylum applicants—the legitimacy of their claim notwithstanding—whose trauma has altered their "demeanor, candor, or responsiveness" may now be perceived as less credible.[18]

The doubling in the number of evaluations performed in detention centers by student-run clinics might be driven by the current administration's 2017 policies of detaining undocumented immigrants and of increasing the capacity of detention facilities to 48,000 detainees per day.[19] The administration's implementation of 'expedited deportation' policies in 2017 has also contributed to the backlog of pending immigration court cases.[20] Many asylum seekers now face prolonged detentions that span months or even years owing to longer waiting periods between an applicant prevailing in a credible-fear interview and subsequently appearing in immigration court.[21] Obtaining access to detention centers to conduct

evaluations remains critical for ensuring a fair adjudication process for asylum seekers.

Of the clients whose cases were adjudicated, asylum or another form of legal protection was received by 95% of clients seen by the WCCHR and by 97.4% of clients seen by all of the student-run clinics, numbers that closely agree. These grant rates accord with those reported elsewhere, suggesting that evaluations performed through student-run asylum clinics are non-inferior to those performed by independent clinicians.[22] Obtaining outcomes data is limited, however, by several factors. The long delays in immigration proceedings hinder a clinic's ability to track results: individuals with open immigration cases—including asylum seekers—have already been awaiting a decision for 727 days on average.[23] Moreover, those denied asylum may appeal and subsequently prevail in their asylum case. Other limitations to accurately measuring asylum outcomes include non-response bias and missing data. Because asylum grant rates vary widely across states, the rates found in this study may not be attainable by every organization.

Training statistics

Between 2016 and 2017, the numbers of clinicians trained by the WCCHR and by seven student-run asylum clinics increased nearly fourfold and fivefold, respectively. The number of students trained also increased over this time period. Asylum evaluation trainings are typically held in September, October, and early spring. The trainings hosted by student-run clinics in 2016 therefore occurred before the 2016 presidential election, whereas the 2017 trainings followed the presidential inauguration. The WCCHR held a training in February 2017 that was—at the time—the largest in the organization's history. The rhetoric surrounding the 2016 election appears to have spurred student-run asylum clinics to broaden their recruitment strategies and to have galvanized clinicians into leveraging their training to assist asylum seekers.[24]

More than 1,400 clinicians and 1,800 students have attended one of 66 trainings hosted by student-run organizations. Asylum clinics retain only a fraction of trainees, however: nearly 400 clinicians and approximately 1,000 students were actively involved in performing forensic evaluations by the end of 2018. Moreover, the need for more trained clinicians to meet the demand for forensic evaluations was the most commonly faced challenge reported by clinics. Clinicians with expertise evaluating minors are increasingly needed: unaccompanied children account for half of the affirmative-asylum applicants from Central America, and this proportion is expected to grow.[25] Expanding opportunities for health care professionals to attend trainings remains integral to the continued growth of clinics nationwide.

Current political context and asylum law

Settled law that offers asylum to certain groups, particularly those claiming persecution due to domestic and gang violence, has been rolled back and challenged by the US Department of Justice. The Board of Immigration Appeals in 2014 held that "married women in Guatemala who are unable to leave their relationship" are a particular social group for purposes of obtaining asylum and withholding of removal.[26] On June 11, 2018, Former Attorney General Jeff Sessions issued a decision, *Matter of A-B-*, that advised immigration officials to summarily deny credible-fear hearings for domestic violence or gang-related claims. Although the attorney general acknowledged the severity of the harms suffered, he questioned whether these survivors are recognized within their society as a particular social group.[27] The proportion of asylum seekers granted protection from the Northern Triangle countries of Central America rose from 14% in 2010 to 27% in 2016, reflecting immigration officials' recognition of the dangerous conditions—including powerful gangs and rampant gender-based violence—pervading the region. Owing to concerted efforts by the Trump Administration to limit asylum eligibility, this upward trend reversed course: grant rates for asylum applicants from Central America declined by 40% between 2017 and 2018.[28] Consistent with these changes, several respondents (40%) noted differences in how

domestic violence and gang violence cases were managed by the organization or by attorneys.

Starting on January 29, 2018, USCIS changed the way asylum claims were adjudicated by prioritizing the most recently filed affirmative asylum applications when scheduling interviews.[29] This compressed timeline can increase stress for applicants as they attempt to gather documents quickly, and it also likely accounts for the increase in urgent evaluation requests reported by three clinics.

Student-run asylum clinics: Challenges and benefits

Respondents indicated that many of the greatest challenges were encountered in establishing a clinic. Particular difficulties at the outset included: addressing risk management, receiving institutional support, transitioning student leaders, recruiting clinicians, and acquiring funding. To help anticipate and preemptively address these challenges, members of the PHR National Student Advisory Board compiled the collective wisdom of several clinics into a guide that delineates the critical steps in founding and operating a student-run clinic.[30] The board's Asylum and Refugee Committee stands ready to offer additional advice, share resources, and connect organizations beset by obstacles to clinics that have overcome similar challenges. The successes of the clinics showcased in this study demonstrate that the barriers to starting a clinic are surmountable, a fact that may allow students to garner support from their institutions as they endeavor to open new clinics.

A student-run asylum clinic's value extends beyond providing forensic medical evaluations and hosting asylum evaluation trainings.[31] Through referral networks, clinics connect clients to local organizations that provide low-cost or *pro bono* medical and social services. By pooling resources and by serving as an organizational hub, an asylum clinic can surpass the number of evaluations performed by independent clinicians and can accommodate tighter deadlines. Moreover, a clinic manages the details of scheduling evaluations. Thus relieved of these logistical burdens, clinicians can focus their time on performing evaluations. Clinics across the nation ascribe to a common set of policies and procedures that were developed with oversight from PHR to ensure the uniform application of acceptable standards of practice. Notably, the affidavit of a first-time evaluator must receive feedback from an experienced evaluator before the document is submitted to a client's attorney. Education is central to the mission of the student-run asylum clinic. By participating in evaluations and in affidavit writing, students interact with highly vulnerable populations, develop cross-cultural competence, learn how to recognize and document signs of torture, practice trauma-informed interviewing, and become acquainted with ways that clinicians can leverage their training to help those in need outside of providing medical care. Students involved in the clinic's operation also gain leadership experience. Conversely, volunteer clinicians are afforded the opportunity to train and mentor students who are passionate about human rights. A clinic can enhance the entire community's awareness of human rights issues through lecture series and can rapidly mobilize many voices through advocacy initiatives. Several organizations have also engaged in broader conversations by developing robust research programs, as is evidenced by the diverse topics presented at the annual PHR National Student Conference.[32]

Conclusion

In August 2019, the backlog of immigration cases in the US soared to more than 1,000,000, a figure that underscores the immense need for forensic evaluations of asylum seekers.[33] Our study demonstrates a rapid expansion in the collective capacity of student-run asylum clinics to provide evaluations. More than 1,500 evaluations have been conducted by 18 student-run asylum clinics nationwide, a testament to the hard work of the students and clinicians who make these organizations possible. This encouraging trend reveals a growing interest among health care professionals in offering services to asylum seekers and predicts

that student-run asylum clinics will soon provide a significant proportion of urgently needed evaluations. With the help of the PHR National Student Advisory Board, the number of asylum clinics continues to grow annually, and each clinic becomes better equipped to accept more evaluation requests.

Acknowledgments

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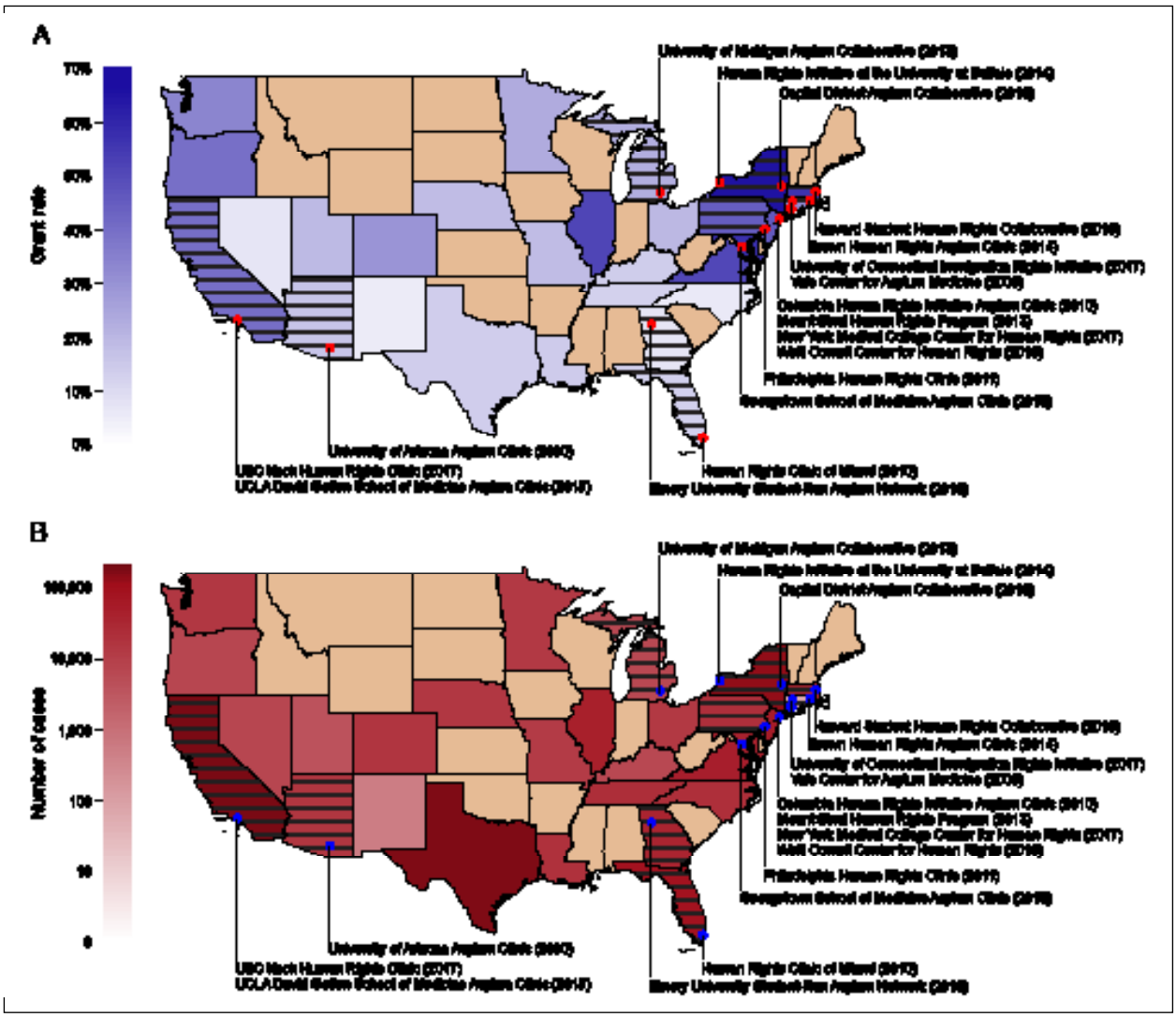
FIGURE S1. Asylum decisions and backlogs by state.



(a) Map showing the statewide rate at which immigration courts granted applicants asylum or another form of legal protection in 2018. This data, taken from TRAC, contains both affirmative and defensive applications decided by immigration courts, but excludes applications decided by USCIS. Darker shades of blue correspond to higher rates along a linear scale as indicated by the color bar. Rates range from 5.5% to 65.6%, the median rate is 21.1%, the national rate across all decisions is 34.7%, and averaging the statewide rates yields 27.8%.
(b) Map showing the backlog of pending cases in the immigration courts by state as of October 2019. Darker shades of red correspond to larger backlogs along a logarithmic scale as indicated by the color bar. In both panels, tan indicates states without immigration courts and striped states are home to student-run asylum clinics that are marked by red (a) or blue (b) dots. Data for both panels were taken from the sources listed in reference 11 of the main text.

References

1. United Nations High Commissioner for Refugees, *Asylum trends 2014: Levels and trends in industrialized countries* (Geneva: UNHCR, 2015).

2. United Nations High Commissioner for Refugees (2015, see note 1); United Nations High Commissioner for Refugees, *Global trends: Forced displacement in 2017* (Geneva: UNHCR, 2018).

3. United Nations High Commissioner for Refugees (2018, see note 2).

4. Ibid.; TRAC Immigration, *Immigration court backlog tool: Pending cases and length of wait by nationality, state, court, and hearing location*. Available at https://trac.syr.edu/phptools/immigration/court_backlog/.

5. Department of Homeland Security, *Granted asylum affirmatively or defensively: Fiscal years 1990 to 2017* (Washington, DC: DHS, 2019); S. L. Lustig, S. Kureshi, K. L. Delucchi, et al., "Asylum grant rates following medical evaluations of maltreatment among political asylum applicants in the United States," *Journal of Immigrant and Minority Health* 10/1 (2008), pp. 7-15; TRAC Immigration, *Asylum decisions and denials jump in 2018*. Available at https://trac.syr.edu/immigration/reports/539/; TRAC Immigration, *Relief granted by immigration judges as of May 2019*. Available at https://trac.syr.edu/phptools/immigration/court_backlog/apprep_relief.php.

6. United Nations High Commissioner for Refugees, *Istanbul Protocol: Manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment* (Geneva: UNHCR, 2004).

7. E. Scruggs, T. C. Guetterman, A. C. Meyer AC, et al., " 'An absolutely necessary piece': A qualitative study of legal perspectives on medical affidavits in the asylum process," *Journal of Forensic and Legal Medicine* 1/44 (2016), pp. 72-78; H. Ferdowsian, K. McKenzie, and A. Zeidan, "Asylum medicine: Standard and best practices," *Health and Human Rights Journal* 21/1 (2019), pp. 215.

8. E. Emery, C. Stellar, K. Dubin, et al., "Student leadership in the creation and operation of an asylum clinic," *Health and Human Rights Journal* (2015). Available at https://www.hhrjournal.org/2015/11/student-leadership-in-the-creation-and-operation-of-an-asylum-clinic/; K. Chelidze, N. Sirotin, M. Fabiszak, et al., "Documenting torture sequelae: the Weill Cornell model for forensic evaluation, capacity building, and medical education," in B. N. Lawrence and G. Ruffer (eds), *Adjudicating refugee and asylum status: The role of witness, expertise, and testimony* (New York: Cambridge University Press, 2015), pp. 166–179; N. Praschan, R. Mishori, and N. Stukel, "A student-run asylum clinic to promote human rights education and the assessment and care of asylum seekers," *Journal of Student-Run Clinics* 2/2 (2016); S. G. Carbrey, B. Cesar, A. Chava, et al., "The value of medical students in support of asylum seekers in the United States," *Families, Systems, and Health: The Journal of Collaborative Family Healthcare* 36/2 (2018), pp. 230–232.

9. Ferdowsian et al. (see note 7).

10. Lustig et al. (see note 5).

11. TRAC Immigration (see note 4); TRAC Immigration, *Asylum decisions by custody, representation, nationality, location, month and year, outcome and more*. Available at https://trac.syr.edu/phptools/immigration/asylum/.

12. Ibid.

13. Physicians for Human Rights, *Securing justice: Physicians for Human Rights annual report 2016* (New York: PHR, 2017). Available at https://phr.org/wp-content/uploads/2018/09/ phr-2016-annual-report.pdf; Physicians for Human Rights, *Through evidence, change is possible; Physicians for Human Rights annual report 2017* (New York: PHR, 2018). Available at https://s3.amazonaws.com/PHR_Reports/PHR_2017_Annual_Report.pdf.

14. N. Mossaad, *Annual flow report refugees and asylees: 2017* (Washington, DC: Department of Homeland Security, March 2019).

15. K. Lee, "Seeking sanctuary," *Monitor on Psychology* 48/7 (2017), pp. 38. Available at https://www.apa.org/monitor/2017/07-08/sanctuary.

16. K. C. McKenzie, J. Bauer, and P.P. Reynolds, "Asylum seekers in a time of record forced global displacement: The role of physicians," *Journal of General Internal Medicine* 34/1 (2019), pp. 137–143; K. Baker, K. Freeman, G. Warner, and D. M. Weissman, *Expert witnesses in U.S. asylum cases: A handbook* (Chapel Hill: University of North Carolina at Chapel Hill, School of Law, 2018); S. M. Meffert, K. Musalo, D. E. McNiel. and R. L. Binder, "The role of mental health professionals in political asylum processing," *The Journal of the American Academy of Psychiatry and the Law* 38/4 (2010), pp. 479–489.

17. US Citizen and Immigration Services, *Credible fear FAQ*. Available at https://www.uscis.gov/faq-page/credible-fear-faq#t12831n40220.

18. Baker et al. (see note 14); US Citizen and Immigration Services, *Credible fear FAQ* (see note 17).

19. Human Rights First, *Tilted justice: Backlogs grow while fairness shrinks in U.S. immigration courts* (Washington, DC, and New York: Human Rights First, 2017). Available at https://www.humanrightsfirst.org/sites/default/files/hrf-tilted-justice-final%5B1%5D.pdf.

20. J. Preston and A. R. Calderon, "Trump tried to deport people faster. Immigration courts slowed down instead," *The Marshall Project* (July 2019). Available at https://www.themarshallproject.org/2019/07/16/trump-tried-to-deport-people-faster-immigration-courts-slowed-down-instead.

21. Human Rights First (2017, see note 19).

22. Emery et al. (see note 8); Lustig et al. (see note 5); R. Asgary, P. Saenger, L. Jophlin, and D. C. Burnett, "Domes-

tic global health: A curriculum teaching medical students to evaluate refugee asylum seekers and torture survivors," *Teaching and Learning in Medicine* 25/4 (2013), pp. 348–357.

23. TRAC Immigration (*Immigration court backlog tool,* see note 4).

24. G. Reich, "Hitting a wall? The Trump Administration meets immigration federalism," *Publius: The Journal of Federalism* 48/3 (2018) pp. 372–395.

25. Human Rights First (2017, see note 19).

26. U.S. Department of Justice, *Matter of A-R-C-G- et al., Respondents* (August 26, 2014). Available at https://www.justice.gov/sites/default/files/eoir/legacy/2014/08/26/3811.pdf.

27. U.S. Department of Justice, *Matter of A-B-, Respondent* (June 11, 2018). Available at https://www.justice.gov/eoir/page/file/1070866/download.

28. Human Rights First, *Central Americans were increasingly winning before President Trump took office* (January 2019). Available at https://www.humanrightsfirst.org/resource/central-americans-were-increasingly-winning-asylum-president-trump-took-office.

29. U.S. Citizenship and Immigration Services, *Affirmative asylum interview scheduling* (January 2018). Available at https://www.uscis.gov/affirmative-asylum-scheduling.

30. Physicians for Human Rights National Student Program, *The asylum clinic guide.* Available at https://www.phrstudents.com/how-to-efficiently-run-an-asylum-pr.

31. Emery et al. (see note 8), Chelidze et al. (see note 8), Praschan et al. (see note 8), Carbrey et al. (see note 8).

32. Physicians for Human Rights National Student Program, *2017 national conference poster archive.* Available at https://www.phrstudents.com/2017-national-conference-posters; Physicians for Human Rights National Student Program, *2018 national conference poster archive.* Available at https://www.phrstudents.com/2018-national-conference-posters.

33. TRAC Immigration (*Immigration court backlog tool,* see note 4).

Appendix

Student-Run Asylum Clinic Impact Survey

1. My organization consents to allowing the PHR Student Advisory Board to pool the information we provide through this survey to create and disseminate a report that evaluates the impact of student-run asylum clinics:
    a. My organization consents
    b. My organization does not consent

2. Your Organization's Information
    a. Name of your organization:
    b. Contact email for your organization:
    c. In what year was your organization founded?
    d. What are your organization's primary sources of forensic evaluation requests?

3. Clinic Caseload
    a. How many forensic evaluations did your organization perform in 2017?
    b. Of those, how many were physical evaluations?
    c. How many were psychological evaluations?
    d. How many were gynecological evaluations?
    e. How many were performed in detention facilities (including detention centers, jails, etc.)?
    f. Did your clinic perform any other type of forensic evaluation in 2017? If so, what types and how many?
        i. Examples include, but are not limited to, dental evaluations, radiographic imaging for forensic purposes, medical record reviews, evaluating whether medical treatments in other countries would be effective for certain conditions (i.e. HIV).
    g. How many clients did your organization evaluate in 2017?
        i. Some clients may receive multiple evaluations; we therefore also want to know how many individual clients your organization has seen.
    h. How many forensic evaluations has your organization performed since it was founded?
    i. Of those, how many were physical evaluations?
    j. How many were psychological evaluations?
    k. How many were gynecological evaluations?
    l. How many were performed in detention facilities (including detention centers, jails, etc.)?
    m. Has your clinic performed any other type of forensic evaluation? If so, what types and how many?
        i. Examples include, but are not limited

to, dental evaluations, radiographic imaging for forensic purposes, medical record reviews, evaluating whether medical treatments in other countries would be effective for certain conditions (i.e. HIV).

n. How many clients has your organization evaluated since it was founded?

i. Some clients may receive multiple evaluations; we therefore also want to know how many individual clients your organization has seen.

o. How does the volume of forensic evaluation requests received by your organization compare with its capacity to perform evaluations?

i. The number of forensic evaluation requests we receive exceeds our organization's capacity.

ii. The number of forensic evaluation requests we receive is commensurate with our organization's capacity.

iii. Our organization's capacity for forensic evaluations exceeds the number of requests we receive.

4. Client Outcomes

a. Of the clients whose cases have been adjudicated, how many have been granted asylum or another form of legal protection?

b. Of the clients whose cases have been adjudicated, how many were denied asylum or other forms of legal protection?

5. Asylum Evaluation Trainings

a. How many asylum evaluation trainings did your organization hold in 2017?

b. How many clinicians did your organization train in 2017 to perform forensic evaluations?

c. How many students did your organization train in 2017 to participate in forensic evaluations?

d. How many total asylum evaluation trainings has your organization held?

e. How many total clinicians has your organization trained to perform forensic evaluations?

f. How many total students has your organization trained to participate in forensic evaluations?

6. Current Involvement

a. How many clinicians are currently involved in performing forensic evaluations with your organization?

b. How many students are currently involved in performing forensic evaluations with your organization?

c. Does your clinic provide services in addition to forensic evaluation?

i. Yes

1. If yes, please give a short description:

ii. No

7. Challenges

a. Has your clinic faced any challenges during the past year? If so, was your organization able to address those challenges? Would you like to discuss any of these challenges with other student-run asylum clinics?

b. Would your organization be interested in participating in another summit for student-run asylum clinics like the event hosted by Cornell in May of 2017?

i. Yes

ii. No

c. Have recent legislation changes affected the way in which your clinic operates?

i. Yes

1. If yes, in what ways?

ii. No

8. Questions

a. Do you have any questions for the PHR Student Advisory Board's Asylum Committee at this time?

Respect, Protect, and Fulfill—or Reject, Neglect, and Regress? Children's Rights in the Time of the Russian "Gay Propaganda Law"

CAROLINE H. VOYLES AND MARIANA CHILTON

Abstract

The "gay propaganda law"—criminalizing public messaging supporting sexual and gender minority (SGM) communities in the presence of youth—implemented within Russia in 2013 has been widely criticized by those in the international field of human rights, yet remains in effect. Although the law is supposedly protecting the well-being of children, it is likely detrimental to youth who may be sexual or gender minorities. This paper uses the 2018 conviction of a minor for violating this law to frame a discussion concerning how Russia, rather than progressively respecting, protecting, and fulfilling the rights of its people, is rejecting, regressing, and neglecting its rights obligations. In particular, we consider the rights outlined in the Convention on the Rights of the Child and the International Covenant on Civil and Political Rights to determine ways in which the Russian state could redirect its actions to support human rights for SGM people and their allies.

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Introduction

Sexual and gender minorities (SGM)—including lesbian, gay, bisexual, and transgender (LGBT) people—experience significant discrimination and stigmatization in many places around the world. While in some countries laws and policies have become progressively more inclusive of SGM individuals, others have become more hostile in recent years. Human rights abuses along the lines of sexual orientation and gender identity have been documented in Russia. One with the most widespread media attention in recent years has been what is known as the "gay propaganda law."

Widely considered to be a direct attack on SGM populations, this law, passed in June 2013, banned the distribution to minors of materials that feature "nontraditional sexual relations."[1] The European Court of Human Rights determined in 2017 that the law was discriminatory and "served no legitimate public interest."[2] Despite this, the law remains intact and SGM individuals and their allies—including the minors whom the state seemed so eager to protect—remain in danger of prosecution.

In July 2018, 16-year-old Maxim Neverov, a political activist known for his organization of "Gays or Putin" performances, was determined to have violated this law by posting a photo of two shirtless men embracing each other to VKontakte, a social media website.[3] Similar to Facebook, VKontakte allows individuals to post images and text publicly or privately and send messages to one another. The action taken by the Russian state against Neverov was the first instance of a child being convicted of violating the "gay propaganda law." Upon his conviction, Neverov was fined 50,000 rubles, approximately double an average Russian's monthly salary.[4] In October 2018, Neverov won an appeal of his conviction, with the judge stating that there was not enough evidence for a guilty verdict. It is unclear how the Russian state will proceed in its prosecution of these supposed crimes, particularly against minors. However, Russian officials have set a dangerous precedent of putting children's rights at risk due to ongoing state discrimination against the rights of people who are SGM.

The example of Neverov's case demonstrates ongoing human rights violations that Russia has committed since the European Court of Human Rights' ruling. In particular, these actions go against the standards set by the Convention on the Rights of the Child and the International Covenant on Civil and Political Rights. These two legally binding instruments and the study of Neverov's conviction create a framework for characterizing how Russia causes harm to children through the violation of their fundamental human rights. The state is criminalizing and endangering children not only in order to further its homo-transphobic agenda and erase sexual and gender diversity but also to silence dissention among its people. Rather than progressively respecting, protecting, and fulfilling the rights of its people, the Russian government is rejecting, regressing, and neglecting its human rights obligations. In this paper, we outline how the rights enshrined in multiple human rights instruments, including the rights to access to information, to freedom of expression, and to privacy, have been violated in the Neverov case, ultimately putting Russian children's rights to health and to life in jeopardy.

REJECT: The Russian state is denying children of information that can benefit their well-being by criminalizing their possession of "propaganda."

Stigma and discrimination negatively affect physical and mental health, including for SGM youth. Stigma exists at multiple levels—individual, interpersonal, and structural—and each level has its own associations with physical health outcomes that are found to be higher among SGM youth than among the general population.[5] For example, internalized homophobia at the individual level has been associated with sexual risk behaviors, including those that put individuals at risk of contracting HIV.[6] This is of particular concern given the "severe, widespread, and geographically dispersed HIV epidemic" currently affecting Russia.[7] Substance use among SGM youth has also been found to be associated with stigma and discrimination at the structural and individual levels.[8] Russia has one of

the highest levels of alcohol consumption per capita in the world, and needle sharing among those who inject drugs is the most common risk for contracting HIV in the country.[9] Clearly, the stigmatization of certain behaviors, people, and identities may be contributing to these poor health outcomes. In this context, the "gay propaganda law" and its criminalization of efforts that demonstrate acceptance of sexual and gender minorities contributes to stigma and therefore to poor physical health for those who identify as or are perceived to be SGM.

SGM youth also have higher rates of negative mental health outcomes, including suicidal ideation and depression, compared to heterosexual youth.[10] These differences have been found to likely be the result of external factors such as stress, lack of social support and coping, and discrimination related to being a stigmatized minority rather than being inherent to sexual or gender minority status.[11] Lacking access to the gay community contributes to distress and depression among men who have sex with men.[12] Because sexual and gender minority identities are often hidden and SGM communities are not geographically bound, social isolation may be a particular challenge for SGM youth and contribute to a greater likelihood of suicidality.[13] As many parts of Russia are sparsely populated, this makes the internet a place through which SGM youth can learn that there are others in the world who share their same-sex attraction or gender identity, potentially alleviating isolation.

Russia's criminalization of Neverov's image postings contradicts articles 13 and 17 of the Convention on the Rights of the Child, which was ratified by Russia in 1990. Article 13 states that children have the right to the freedom of expression, including the right "to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally in writing, or in print, in the form of art, or through any other media of the child's choice."[14] Neverov's choice to possess and post these photos falls well within this right to seek and receive information. Moreover, article 17 of the convention notes that states "shall ensure that the child has access to information and material from a diversity of national and international sources, especially those aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health."[15] Whether or not Neverov himself is LGBT, sharing an image that promotes tolerance of non-heterosexual relationships is likely supportive of physical, mental, and social well-being for SGM individuals, as SGM-tailored social media usage has been found to support resilience and mental well-being, as well as connectedness to SGM communities.[16]

Preventing children such as Neverov from obtaining information or images pertaining to same-sex attraction is a rejection of SGM status as an acceptable identity for young people. In order to *fulfill* the rights of children to achieve the highest attainable standard of health, the state must ensure that information relating to a diversity of sexual and gender identities and behaviors is accessible to children in an age-appropriate manner.

REGRESS: The Neverov case demonstrates Russia's willingness to unlawfully harass SGM children.

Some observers have described the human rights violations stemming from the arrest of adults who have violated the "gay propaganda law," arguing that the state is not progressively meeting human rights obligations as is required by international human rights law.[17] The European Court of Human Rights' 2017 ruling presented an opportunity for Russia to redirect its actions concerning SGM activism and the SGM community in general. However, the Neverov case presents an example of the state's continued regression, in light of Neverov's status as a child and as a political activist.

Neverov had previously been known to Russian authorities for his civil rights activism.[18] That he was the first minor to be found in violation of the "gay propaganda law" is likely not a coincidence, as it may have been the government's attempt to silence his speaking out against state policies and actions. Additionally, this case is not the first time that Russia has punished children for opposing governmental actions or policies; for example, in 2018, children were among those arrested for peacefully

protesting against Putin's inauguration.[19] Given that article 15 of the Convention on the Rights of the Child states that governments should recognize children's rights to freedoms of association and to peaceful assembly, Russia is engaging in unlawful harassment of children.[20]

Despite these precedents, the Neverov case demonstrates a continued regression in the government's rights obligations. Neverov's status as a political activist is a likely reason for having been found in violation of the "gay propaganda law," which exhibits discrimination on the basis of law enforcement. Article 26 of the International Covenant on Civil and Political Rights states that all persons are entitled to equal and effective protection against discrimination, including on the grounds of political or other opinion.[21] That this law was selectively enforced in order to silence political dissention is a failure of the state to respect the right to be free from such discrimination. In order to *respect* children's rights to peaceful assembly and protection from discrimination on the basis of political opinion, the Russian state should refrain from punishing peaceful protestors to begin with, as well as from using the "gay propaganda law" as a pretext for doing so.

NEGLECT: Arresting individuals for "propaganda" reveals potential SGM status in a hostile environment.

If Russian officials continue to reveal potential SGM individuals in the country's currently homophobic climate, there are likely to be serious public health implications, such as increased anxiety and interpersonal violence. Stigma against people who are SGM has been high in Russia in recent years. As revealed by a 2017 poll that surveyed 1,600 people in 48 Russian regions, 80% of respondents rated homosexual sex as "reprehensible," a sizeable increase since both 1998 and 2008.[22] Similarly, physical hate crimes in Russia have dramatically increased since the "gay propaganda law" took effect, with some resulting in murder.[23] Violence against those who are or are perceived to be SGM is not only associated with death and injury but also likely to cause a heightened sense of fear among those who feel they could be targets. Given that fear of victimization has been found to be associated with depression and other poor physical and social health outcomes, this may result in furthering the public health burden for SGM populations and contributing to health disparities.[24]

Although Neverov had already been in the public eye, the international attention drawn by this case has potentially made him a target of homophobic violence, regardless of whether he himself identifies as SGM. In this way, the Russian state has put him at additional risk. This is particularly concerning as, since the case broke, a "gay hunting" website has published SGM rights activists' personal information, with the encouragement to "hunt" them down. Although the site has now been removed, at least one activist appears to have been murdered in the wake of such a hate-based posting.[25] Neverov's safety may already have been at risk, as during his appeal process, he was reported to have said that his phone number and address had been posted online by authorities in light of some of his previous activism.[26] The increased attention specific to "gay propaganda" may decrease his real or perceived safety. This violates both the Convention on the Rights of the Child and the International Covenant on Civil and Political Rights, which state that "every human being [child] has the inherent right to life."[27] Additionally, in a document specifically addressing issues of sexual orientation and gender identity, the Office of the United Nations High Commissioner for Human Rights notes that states must attempt to "prevent, punish, and redress deprivations of life, and investigate and prosecute all acts of targeted violence."[28] While this document is in itself not legally binding, it provides clarification regarding how SGM identities are protected as an "other status" in the documents that are legally enforceable.

In order to *protect* children's rights to life and health, the Russian state should not punish individuals for their possession of any materials considered to be "gay propaganda," as this can have the effect of encouraging further negative attention and violence directed at these particular individuals.

Conclusion

The human rights framework outlines how states must progressively respect, protect, and fulfill its human rights obligations, including for SGM populations or those who may be perceived to be SGM. The "gay propaganda law" and its recent enactment may have been the canary in the coal mine, signaling Russia's movement away from supporting the human rights of SGM communities.

The case of Maxim Neverov demonstrates the state's complete disregard of the European Court of Human Rights' ruling on the discriminatory nature of this policy and is a violation of international human rights. The enforcement of this law against an even more vulnerable population—SGM youth—in the face of the court's ruling suggests that Russia may stop at nothing in its quest to eliminate any identity or expression that challenges cisgender and heterosexual norms. Prior to the eventual overturning of Neverov's conviction, this case exhibited a clear *regression* in Russia's meeting of its human rights obligations in addition to a *rejection* of SGM status as an acceptable option for children and *neglect* of its SGM people by fanning the flames of violence.

That Neverov won his appeal due to inadequate evidence of guilt is a sign that some Russian officials acknowledge that the state had gone too far in its attempts to stifle SGM expression. The setting of a precedent for appeal is a step toward supporting the rights of SGM people and their allies in Russia, but repealing the law is necessary to reduce the detrimental impacts on health and human rights. A 2019 ranking by ILGA-Europe scored Russia as the fourth least LGBT-friendly European nation, with repeal of the "gay propaganda law" being one of three recommendations for improving the plight of SGM people in the nation.[29] While the Russian legal system successfully defended human rights in the case of Neverov, a public health approach may facilitate further rights protection in years to come. This could occur through research on the effects of the law, nationwide policy change in its repeal, and tailored health education supporting the mental and physical health of SGM Russian children and adults. This may help ensure that SGM children feel free to express themselves and flourish in private and public in Russia and around the globe.

References

1. Associated Press, "Russia passes anti-gay law," *Guardian* (June 30, 2013). Available at https://www.theguardian.com/world/2013/jun/30/russia-passes-anti-gay-law.
2. S. Chan, "Russia's 'gay propaganda' laws are illegal, European court rules," *New York Times* (June 20, 2017). Available at https://www.nytimes.com/2017/06/20/world/europe/russia-gay-propaganda.html.
3. A. Cooper, "'Not scared': Russian teen charged under 'gay propaganda' law says he'll keep protesting," *NBC News,* (August 14, 2018). Available at https://www.nbcnews.com/feature/nbc-out/not-scared-russian-teen-charged-under-gay-propaganda-law-says-n900566.
4. Ibid.
5. M. L. Hatzenbuehler and J. E. Pachankis, "Stigma and minority stress as social detrminants of health among lesbian, gay, bisexual, and transgender youth: Research evidence and clinical implications," *Pediatric Clinics* 63/6 (2016), pp. 985–997.
6. M. Rosario, E. W. Schrimshaw, and J. Hunter, "A model of sexual risk behaviors among young gay and bisexual men: Longitudinal associations of mental health, substance abuse, sexual abuse, and the coming-out process," *AIDS Education and Prevention* 18/5 (2006), pp. 444–460; M. L. Hatzenbuehler, S. Nolen-Hoeksema, and S. J. Erickson, "Minority stress predictors of HIV risk behavior, substance use, and depressive symptoms: Results from a prospective study of bereaved gay men," *Health Psychology* 27/4 (2008), pp. 455–462.
7. C. Beyrer, A. L. Wirtz, G. O'Hara, et al., "The expanding epidemic of HIV-1 in the Russian Federation," *PLoS Medicine* 14/11 (2017), p. e1002462.
8. M. L. Hatzenbuehler, H.-J. Jun, H. L. Corliss, and S. B. Austin, "Structural stigma and sexual orientation disparities in adolescent drug use," *Addictive Behaviors* 46 (2015), pp. 14–18; G. Weber, "Using to numb the pain: Substance use and abuse among lesbian, gay, and bisexual individuals," *Journal of Mental Health Counseling* 30/1 (2008), pp. 31–48.
9. V. Paznyak and D. Revke, *Global status report on alcohol and health 2014* (Geneva: World Health Organization, 2014); Beyrer et al. (see note 7).
10. J. Almeida, R. M. Johnson, H. L. Corliss, et al., "Emotional distress among LGBT youth: The influence of perceived discrimination based on sexual orientation," *Journal of Youth and Adolescence* 38/7 (2009), pp. 1001–1014.
11. Ibid; S. A. Safren and R. G. Heimberg, "Depression, hopelessness, suicidality, and related factors in sexual minority and heterosexual adolescents," *Journal of Consulting and Clinical Psychology* 67/6 (1999), pp. 859–866.

12. T. C. Mills, J. Paul, R. Stall, et al., "Distress and depression in men who have sex with men: The Urban Men's Health Study," *American Journal of Psychiatry* 161/2 (2004), pp. 278–285.

13. I. Rivers, C. Gonzalez, N. Nodin, et al., "LGBT people and suicidality in youth: A qualitative study of perceptions of risk and protective circumstances," *Social Science and Medicine* 212 (2018), pp. 1–8.

14. Convention on the Rights of the Child, G.A. Res 44/25 (1989), art. 13.

15. Ibid.

16. E. S. K. Chong, Y. Zhang, W. W. S. Mak, and I. H. Y. Pang, "Social media as social capital of LGB individuals in Hong Kong: Its relations with group membership, stigma, and mental well-being," *American Journal of Community Psychology* 55/1 (2015), pp. 228–238.

17. S. Polsdofer, "Pride and prejudiced: Russia's anti-gay propaganda law violates the European Convention on Human Rights," *American University International Law Review* 29/5 (2014), pp. 1069–1096.

18. Cooper (see note 3).

19. T. Lokshina, "From kids to leaders, Russia cracks down on protestors" (May 2018). Available at https://www.hrw.org/news/2018/05/23/kids-leaders-russia-cracks-down-protesters.

20. Convention on the Rights of the Child, G.A. Res 44/25 (1989), art. 15.

21. International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI) (1966), art. 26.

22. "Four out of five Russians find gay sex 'reprehensible' – poll," *Moscow Times* (January 2018). Available at https://www.themoscowtimes.com/2018/01/11/four-out-of-five-russians-against-gay-sex-poll-a60159.

23. D. Litinova, "Anti-LGBTQ hate crimes double in Russia following 'gay propaganda' law," *HuffPost* (November 2017). Available at https://www.huffpost.com/entry/russia-gay-propaganda-hate-crimes_n_5a148f8fe4b09650540df5b7.

24. M. Stafford, T. Chandola, and M. Marmot, "Association between fear of crime and mental health and physical functioning," *American Journal of Public Health* 97/11 (2007), pp. 2076–2081.

25. R. Thebault, "A horror-themed website told readers to 'hunt' gay people. Then an activist was stabbed to death," *Washington Post* (July 2019). Available at https://www.washingtonpost.com/world/2019/07/24/russian-lgbtq-activist-yelena-grigorieva-found-dead-st-petersburg.

26. Cooper (see note 3).

27. Convention on the Rights of the Child, G.A. Res 44/25 (1989), art. 6; International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI) (1966), art. 6.

28. United Nations High Commissioner for Human Rights, Discriminatory laws and practices and acts of violence against individuals based on their sexual orientation and gender identity, UN Doc. A/HRC/19/41 (2011).

29. ILGA-Europe, "Rainbow Europe 2019" (May 2019). Available at https://www.ilga-europe.org/rainboweurope/2019; ILGA-Europe, *Annual review of the human rights situation of lesbian, gay, bisexual, trans and intersex people in Europe 2018* (Brussels: ILGA-Europe, 2018).